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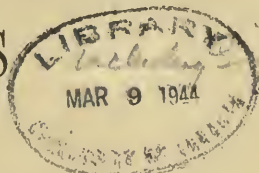
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ORIGINAL COMMUNICATIONS.

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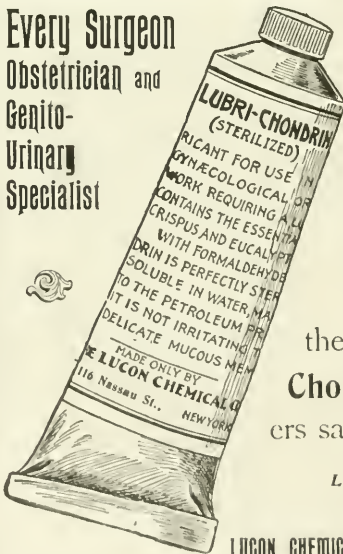
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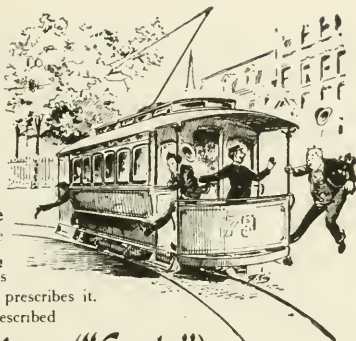
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JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

VOL. XX.

JANUARY, 1902.

No. 1.

Original Communications.

TWO CASES OF A RARE PAPULAR DISEASE AFFECTING THE AXILLARY REGION.

BY GEORGE HENRY FOX, M.D.,

WITH A REPORT ON THE HISTOPATHOLOGY.

BY JOHN A. FORDYCE, M.D.,

THE first patient who presented the peculiar eruption which I wish briefly to describe, entered the New York Skin and Cancer Hospital in January, 1899. She was twenty-eight years old, unmarried, and born in Russia. The eruption was mainly confined to the axillary region, had existed for a year or more and caused no little distress. The itching was intense and of a paroxysmal character, robbing her of sleep and impairing her general health in a marked degree. The patient was thin and of a highly neurotic temperament and it was not easy to determine to what extent the impaired health was a cause or a result of the distressing dermatosis.

The eruption was of a papular character and the lesions were numerous, small, firm, smooth and rounded. The skin was deeply infiltrated and slightly fissured. The aggregated papules were of normal color or but slightly reddened, although the scratching produced at times a considerable amount of congestion and excoriation.

Over the pubic region were a number of small rounded papules, evidently of the same nature as those in the axillæ but not accompanied by such intense pruritus. Upon other portions of the body no sign of eczema or other disease was noticeable.

Upon the assumption, after my first examination of the patient, that the eruption was either a chronic lichenoid eczema or one which

would at least yield to the usual treatment of such a condition, a variety of local applications were successively employed. Nitrate of silver, oil of peppermint, tar and chrysarobin were alternated with ichthyol, zinc ointment and carbolated vaseline, and I may add that never in my experience have I seen a case in which local treatment has had less beneficial effect.



Fig. 1. Papular disease of axilla showing papule and dilated sweat coil.
(Spencer 1 in., no ocular.)

Bromides and trional were found necessary to relieve the persistent insomnia, while arsenic and iron, together with compulsory exercise in the open air were prescribed for their tonic effect. At times slight improvement both general and local was noted, but after eleven months in hospital the patient was finally discharged in a condition which clinical accuracy compels me to characterize as "unimproved."

I have met with one other case of this rare, obstinate and distress-

ing affection. This occurred in a young man who was extremely neurotic and suffered much from the intense pruritus. As in the case above reported, the eruption consisted of small, rounded, aggregated and almost colorless papules. It was confined to the axillary region and resisted the ordinary methods of treatment.

HISTOLOGICAL REPORT BY JOHN A. FORDYCE, M.D.

Two papules were removed from the anterior axillary region by the cutaneous punch. They included the deep lying coil glands. The



Fig. 2. Hypertrophy of epidermis with horny plug in sweat-duct orifice.
(S. $\frac{1}{2}$ in. proj. ocular 2.)

excised papules were cut serially in paraffine and stained in various ways. The papules removed were a line or less in diameter and showed little or no evidence of inflammation. The case was only seen once so that the early stages and subsequent evolution of the lesions were not observed.

The most striking change in the skin was a hyperkeratosis covering the papule and extending into the openings of the sweat ducts and hair follicles. The latter in some of the sections were considerably dilated, filled with a horny mass and the hair producing power of the

follicle evidently destroyed. At the sweat pores the stratum corneum was thicker than in other places, the hyperkeratosis extending deeply into the intra-epidermic portion of the duct. The papule appeared to be chiefly of epidermic origin, a considerable degree of acanthosis being present as is seen in the thickened and lengthened interpapillary rete pegs. This epidermic hypertrophy surrounds the sweat ducts and hair follicles and probably results from the hyperkeratosis which extends from the surface.

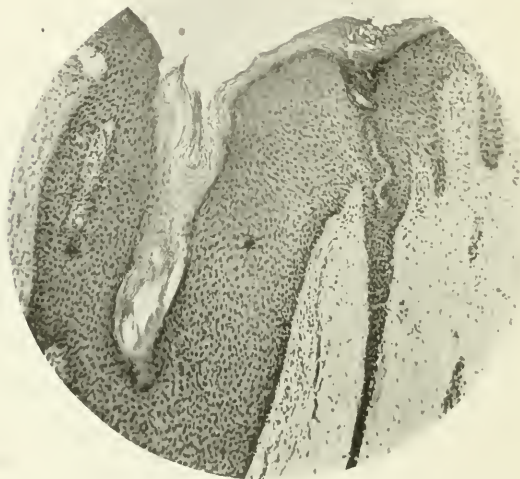


Fig. 3. Hyperkeratosis of sweat-duct and adjacent hair-follicle.
(S. 1 in., proj. ocular 2.)

In Figures 1, 2 and 3 photographs of the sections are shown which illustrate the changes in the epidermis that have been mentioned. The plugging up of the sweat ducts with horny matter results in a pronounced dilatation of the underlying coils and ducts. In figure 1, which is a low power photograph of an entire section, the relationship of the surface changes to the dilatation of the coils is well shown, the serial sections enabling one to readily trace the dilatation of the coils to the surface changes. The hypertrophied rete was evidently of slow growth as very few mitoses were observed. In the derma inflam-

matory changes of a more or less chronic character were seen in exudation of lymphoid cells and a few polynuclear leucocytes about the vessels accompanying the coil ducts. A new growth of connective tissue was also observed in the same locality. The change in the coils is probably primarily a mechanical dilatation due to obstruction, followed by secondary changes in their epithelial lining of a degenerative nature.

The intense itching which was so annoying to the patient may have been due to irritation of the terminal nerve fibers in the epidermis or to the retention of fatty acids or other irritating substances in the sweat.

In brief the histological changes in this case consist (1) of a hyperkeratosis involving chiefly the sweat-duct orifices, their intra-epidermic portions, and the orifices of the hair-follicles. (2) Consecutive hypertrophy of the stratum spinosum (acanthosis) surrounding the altered sweat ducts and hair follicles. (3) Mechanical dilatation of the coil glands which result in changes in their epithelial lining. (4) Inflammatory changes of a more or less chronic character in the derma.

The histological picture here presented is similar to that seen in porokeratosis as can be readily confirmed by comparing the photographs made from my sections with the drawings which accompany Dr. Gilchrist's article (*JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES*, Vol. XVII., page 149).

REPORT OF A CASE OF IDIOPATHIC MULTIPLE SARCOMA OF THE SKIN.

By HENRY H. KOEHLER, M.D.,

Professor of Skin, Genito-Urinary and Venereal Diseases, Kentucky University
Medical Department, Louisville, Ky.

WITH A REPORT ON THE HISTOPATHOLOGY,

By JAS. C. JOHNSTON, A.B., M.D.,

CASES of multiple cutaneous sarcomata are relatively rare but in spite of their infrequency quite a number of clinically different varieties have been described. Histologically, however, they show no such great diversity and they may be divided into spindle celled (fusocellular) and round celled (globocellular).

Unna also described a giant cell sarcoma.

Kaposi classes under sarcoid tumors of the skin several apparently distinct disease entities prominent among which is his idiopathic multiple pigment sarcoma. He also describes under type C., in his text book, another variety, referring to it as simply *Sarcomatosis Cutis*, which differs from the foregoing in many respects. The case I here present exhibits clinically, characteristics of both types. The histological examination, kindly made by Dr. James C. Johnston, shows a greater resemblance to the multiple idiopathic pigment sarcoma than to the other as will be seen by his report. There is an absence though of pigment which in the hemorrhagic variety would naturally be a feature. The patient, however, is of a very fair type, with light blue eyes, reddish hair, and a very white skin, and it may be that a general lack of pigment formation is in a measure responsible for the lighter color of the tumors.

Unna in his "Histopathology of the Skin" makes the following divisions of skin sarcomata. He would first place the so-called melanotic sarcomata among the carcinomata, claiming that he has found abundant microscopical evidence to justify his doing so. The true sarcomata he divides into two great groups, the solitary, and the multiple. Of the multiple he gives the following five varieties:

1. *Sarcoma Multiplex Cutaneum durum album.*
2. *Sarcoma Multiplex Cutaneum durum pigmentosum.*—Piffard.
3. *Sarcoma Multiplex Cutaneum Molle.*—Neumann.
4. *Sarcoma Multiplex Cutaneum gummatodes.*—Funk, Hyde.
5. *Arosarcoma Multiplex Cutaneum teleangiectodes.*—Hebra, Kaposi.

The case here under consideration resembles the description of the first variety closely even to the absence of pigment. Unna regards the fusocellular variety of sarcoma as the main type of the cutis proper since the spindle cells "repeat the normal type of the connective tissue of the skin of adults." A characteristic of the spindle cell variety, as is shown in this case, is the absence of an ulcerative tendency. Ulceration is much more marked in the round cell variety (Type 3 Unna).

Clinical Report: Patient is a Hebrew, born in Russia, and was referred to me by Dr. Leon L. Solomon. He has a good constitution and has always enjoyed good health. He is fairly intelligent and denies ever having had a specific infection. He has been in this country about eight years uninterruptedly and the disease which he is now suffering from developed in 1896. The attack came on immediately after a severe exposure. The patient made a trip to Cincinnati on a boat sleeping in a very warm room. In Cincinnati he slept in a very

cold room and on coming home shortly afterward he noticed the tumors for the first time. The eruption commenced first on the extremities, later on extended to the trunk and face. Dr. Solomon tells me that at

Fig. 1.



times several nodules had ulcerated, although the tendency to this seems to be very slight. He complains of muscular pains very much like those of muscular rheumatism. The nodules themselves are painless and devoid of any subjective sensation. The extirpation of one

caused profuse bleeding but little pain. In the fall of 1900 he had an acute febrile attack after which he had attacks of dizziness with loss of appetite and pains in knees and legs. In May, 1901, he again had similar pains in lower legs and knees. The patient is a pronounced blonde and has hitherto been entirely free from any eruption of any kind, a point upon which he dwells. Patient perspires very freely and claims that he feels himself weakened thereby. His children are healthy. He is about fifty years of age.

Fig. 2.



Present state: Health fairly good. No marked deterioration from former standard. Patient at times has fever. As shown in the photographs the eruption is quite generally distributed and symmetrical. The color of the tumors is a reddish brown somewhat like that of a keloid. A slight purplish tinge is noticed in those on the lower extremities. They are vascular, firm to the touch, elastic with no pain on pressure. The extensor surfaces are more involved than the flexor surfaces. On the forehead the nodules have fused together and give him a leonine expression. The eyelids are much infiltrated. On the top of the larger tumors there is a distinct condition of telangiectasis.

No ulceration anywhere at present. Palms and soles are spared. No lymphatic enlargement anywhere. He exhibits no clinical symptoms that point to leukemia or pseudo-leukemia. Since the advent of warm weather slight hemorrhages have taken place in several of the tumors.

Dr. Solomon in referring this case stated that he had at one time given this patient strontium arsenite, by mouth, with some temporary benefit. He is at present receiving injections of sodium arseniate according to the method of Kaposi. In giving them I notice a general hardness of the skin, as shown by marked resistance to the entrance of the hypodermic needle. This treatment has been used for about a month (0.02 gramme every other day) without appreciable affect on these tumors.

Dec. 7.—The patient took the arsenic injections for about two months. Finding no improvement in that length of time he absented himself. During the last few months he has been without treatment and it is quite apparent that his disease has progressed. The infiltration on the forehead has thickened, and innumerable small nodules stud his body between the larger ones. The color has also deepened and the tumors look congested. His health is fairly good, he has lost no flesh and has been able to follow his trade of shoemaker. Lymph-nodes nowhere show any involvement. Urine normal, no casts or albumin. He wishes to return to the arsenic treatment as he believes it at least kept the disease in check. There is not the slightest tendency to ulceration or breaking down of tumor tissue.

Histopathology.—The growth which Dr. Koehler sent me measured about three-eighths of an inch in diameter by one-eighth in thickness, but it is apparent from the sections that not all of its mass was included, either peripherally or below. There is a surface erosion at the center. There can be no reasonable doubt that the histological features are the same in all the tumors, although I can not however make a definite statement on the point since I have had only the one for examination. The microscopical picture is a new one in my experience.

The process evidently begins as most skin sarcomas do in the lower reticular layer and upper hypoderm. It never invades the papillary body and seems limited by the lower level of the coil glands beneath. The upper border is flattened and sharply defined (as in fact the periphery is everywhere) by dense collagenous bands running parallel with the periphery. The condensation with the disappearance of the papillæ and interpapillary projections is the result of pressure from the subjacent tumor. The under and lateral borders show lobulated out-growths into the surrounding skin. In other words, the method of

progression is by a gradual pushing aside of the connective tissue as in epithelial neoplasms, rather than the conversion into new growth which is the way with sarcomas even when an attempt is made at encapsulation. Other striking general features are the absence of reactive inflammation of vessel dilatation, and of pigment of any sort.

In the peripheral, presumably newer, portions there is a close packing of spindle cells whose protoplasm stains lightly with basic dyes

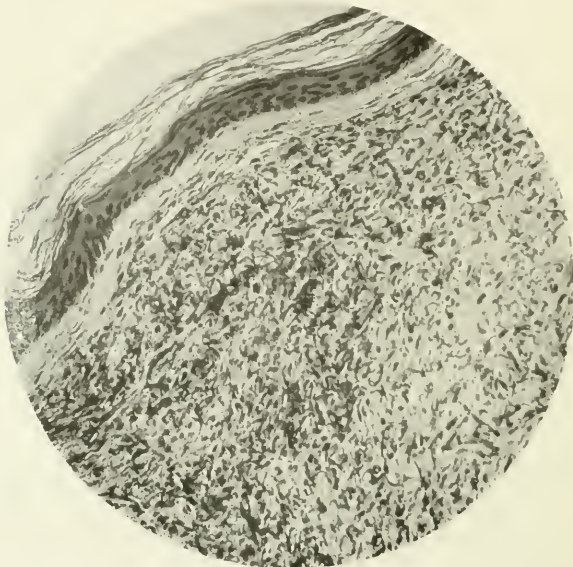


Fig. 3. Periphery of growth showing contorted spindles and disappearance of papillae and interpapillary projections.

and whose outlines are indistinct. Their nuclei stain deeply and diffusely like those of young fibroblasts, but, unlike them, are not uniform in size or shape. The latter is greatly varied; some show thickenings like nodes, others are filamentous, some are shaped like spermatozoa and others still are bent at right angles on themselves. Between them, the delicate reticulum of sarcoma is easily brought out by a fresh picric-acid-fuchsin stain. These nuclear distortions can be due to but one

thing, outside pressure. The reason for the pressure is found in a totally different type of cell lying between the spindles, even where they are most numerous.

At the growing edge, they are overshadowed by the mass of spindles, but in the central portion, the relative numbers are reversed and the spindle cells almost disappear. The second variety is ovoid or polyhedral, with a protoplasm refractory to most stains (picric acid colors it readily) and oval vesicular nuclei with one or two nucleoli. They lie in nests surrounded by a delicate membrane which does not

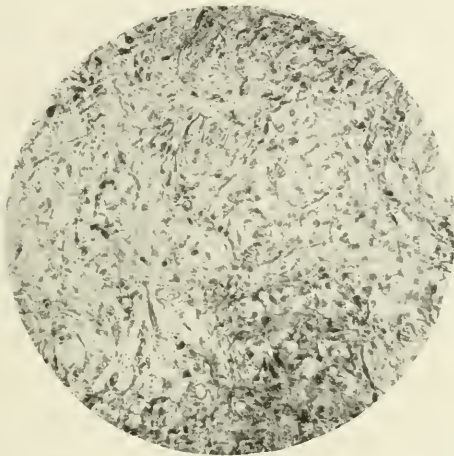


Fig. 4. High power view of an older portion stained with picro-fuchsin to show intercellular reticulum. Spindles have largely disappeared before endothelial new growth.

stain with fuchsin and is not the sarcoma reticulum. With the spindle cells, the reticulum disappears. A lumen may be seen in the center of a very few of the nests or whorls which sometimes contains blood. In certain sections, there appeared a giant cell formation with numbers of small round nuclei, but as it often showed both a central lumen and a clearly defined, limiting membrane, I judged it the remains of coil glands caught in the growth as remnants of collagenous material are ensnared here and there. Mitosis is excessively rare; cell division is direct throughout.

The origin of this second type of cell is not hard to determine. From its morphology and arrangement, it can arise only from proliferative activity in endothelium, from lymphatics and blood capillaries, whether preexistent or newly formed it is impossible to decide. The whole tumor shows very few patent vessels of any sort but in spite of this, there is no necrosis. Even the englobed tissue remnants are in a perfect state of preservation.

It is a well recognized fact that in sarcoma, particularly of the skin, there is in certain instances a tendency to endothelial proliferation as in Kaposi's idiopathic, pigmented sarcoma and the case which I described in a recent article on this subject. (JOURNAL, July, 1901.) There is no reason to suppose that in a given instance every capillary may not show this proliferation with whorl formation, in the course of time, blotting out almost completely the growth with which it first appeared. If this supposition is correct, the tumor should be classed with sarcomas, although I regard endothelioma as much more nearly allied to epithelial than to connective tissue new growths both from histogenetic and morphological standpoints. Among the sarcomas, it is clear that its place is with the Sarcoids for these reasons; there is an absence of the appearance of malignancy, such as infiltration of the surrounding skin, of evidence of rapid cell division, of any striking departure from adult cell types, fibroblastic or endothelial (the types are found in pure processes of productive inflammation), and finally, of the absence of metastases, in lymph nodes or viscera. All these peculiarities are characteristic of the class of cutaneous sarcomas which I think we are obliged to make and for which Sarcoid will serve as well as another name. The sarcoids have a cachexia, however, of their own in spite of failure to metastasize. The tumor in question is most closely allied to Kaposi's multiple, pigmented sarcoma which should be called hemorrhagic. Hemorrhage is of course only an accident, though due to peculiarities of structure. It is not present in our case because the vessels are not only fully formed but occluded. The reason for the failure to respond to the use of arsenic is found in the predominance of the endotheliomatous element. Such tumors do not yield to the drug, the fact of its inefficacy furnishing basis for a grave prognosis. As in other endotheliomas, moreover, it is always possible to develop metastasis under irritation or without any appearance of it.

In conclusion, the tumor is a small, spindle-celled sarcoma with which occurs such endothelial proliferation as to strangle the sarcoma element in the older portion. It is free of pigment, hemorrhagic or metabolic, and belongs to the class of Sarcoids, constituting a new

type but nearly allied to multiple, hemorrhagic sarcoma. Dr. Koehler is within his rights in classing it clinically with the Unna group he has selected.

My thanks are due Dr. B. H. Buxton for the accompanying microphotographs which admirably illustrate the histological features I have attempted to describe.

AN EXTRAORDINARY CASE OF QUININE SUSCEPTIBILITY.*

BY HENRY W. STELWAGON, M.D.,
of Philadelphia.

CASES of eruptive phenomena from the ingestion of quinia preparations are common enough in literature, and fairly well known, and therefore the publication of new instances is probably only justified by some unusual feature or for the purpose of calling attention to the possible confusion of some of these rashes with the exanthemata, especially with the so-called second attacks of the latter. The case which I shall briefly detail is one especially striking on account of the smallness of the dose necessary, the many ways in which the drug, surreptitiously so to speak, gains access, and the uncomfortable results which follow. The patient is a gentleman of good health, robust habit, and at the present time is in middle life. So far as he can recall he has had in all about twenty to twenty-five attacks of a scarlatiniform erythema followed by branny and lamellar and sheet-like desquamation, with more or less accompanying itching, and running a course of several weeks. The cause of the first three or four outbreaks was not even suspected. I saw this gentleman several years previously in one attack in consultation with Dr. H. A. Smith of Philadelphia, who had already seen the patient in one or two other attacks; and who, together with the patient himself, whom I saw a few weeks ago for the purpose of having the data corroborated, has kindly placed at my disposal most of the facts here given. I shall only refer to eight or ten outbreaks.

The attack which threw the first light or suspicion on the probable cause occurred some years ago. At the time the patient was not feel-

* Read at the Twenty-fifth annual meeting of the American Dermatological Association, held at Chicago, May 30, 31 and June 1, 1901. Since reading this paper I find that a brief note of an attack in this case was recently made by Dr. Hare, *Therapeutic Gazette*, May, 1901.

ing up to his usual standard, and consulted a prominent physician in my city, who was then his family attendant, and who prescribed for him quinia in the average dose, the exact amount of which he does not recall; this was immediately followed by a rapid development of a scarlatinous rash, which was thought to be an example of a second attack of scarlet fever. It ran a somewhat similar course, and when it had about passed off, after the resulting exfoliation was practically ended, as he was not feeling in very good condition, a tonic containing quinine was given him to brace him up, and he forthwith had another attack. Some time later, not feeling up to his general tone, he thought he would consult a distinguished surgeon of our city, since deceased, whom he knew both socially and professionally, and stated to him that he felt that he needed a tonic. At the same time he called his attention to his extreme susceptibility to quinia, concerning which the physician remarked that it was all nonsense, and then prescribed for him a mixture of which the basis or vehicle was the elixir of calisaya, each dose containing about one-eighth of a grain. One dose of this mixture was sufficient to apprise him that he had taken the drug, and another outbreak resulted. Another instance was when he dropped in on a relative—a druggist—whom he happened to find just at that moment engaged in the manufacture of a preparation of bitter wine of iron, of which he thought highly, and the enthusiasm of the druggist affecting his visitor, he sipped some, and within an hour or so he was again ushered into another scarlatiniform cycle of a few weeks' duration. At another time, some years ago, he was visiting in Boston, and while out walking with his host or friend, his companion was expatiating upon the merits of a new drink; he was induced to try one, and as one of its good qualities was due to a pleasant bitterness from a trifling amount of calisaya bark, it was but a brief time before the Philadelphian was again in the throes of another outbreak, and his eastern visit was stripped of some of its pleasantness. Once subsequently he was again the victim of an enticing decoction. He and a few friends were on their way northward for a fishing trip; they were joined at an interior Pennsylvania town by a friend who was to go with them, and who, to make his welcome the more hearty, had had prepared and brought on board of the train with him a cocktail for each one of the party—which was properly enjoyed—but the susceptible quinia friend soon found that a cocktail usually contains bitters, of which calisaya is often a representative, and instead of going fishing was obliged to retire and go through the process of again shedding his epidermis.

A few years later at the end of an acute pulmonary disease, as he

was not making rapid progress towards complete recovery, two other physicians were called in as consultants, and who, although made aware of the quinia idiosyncrasy, but not placing the same weight upon it that the patient did, finally agreed that the compound syrup of the hypophosphites, made by a western manufacturing firm, was the right thing for him, considering that the amount of quinia contained therein was practically nil—but one dose of it was enough to bring on another ordeal of the scarlatiniform rash, with its usual course. Some time after this experience, perhaps a year or two, he was on a pleasure visit to a southern sulphur spring resort, and on a social call on a prominent physician there whose name is familiar to us all, and while in his house, in response to a question about his health, casually remarked that he had a slight corvza, and he was kindly offered a rhinitis tablet. Naturally his immediate inquiry was as to whether it contained any quinine, the physician replying that it did not, and in order to convince him and relieve his mental doubt and agitation, showed him the book of formulæ of the firm manufacturing it. It was taken, but it was but a few minutes, however, before the patient became aware that the tablet contained the dreaded drug, and his pleasure visit was turned into several weeks of discomfort, with the initial lobster red skin and the subsequent exfoliation. Unfortunately the book which contained the printed formulæ was an old one, and an inspection of a more recent list showed that the rhinitis formula had been somewhat changed, and now contained one-eighth grain of quinine. It was some months perhaps after this when his family physician was called in to see him, as he was suffering from a slight cold. His physician usually carried with him a small supply of tablets, of which he prescribed some composed of several ingredients, of which the patient was to take one every half hour or hour. Being well aware of his patient's idiosyncrasy, nothing was said on the subject of their composition. The physician had been but a short time at his office, after his return from this visit, when a messenger came from the patient, asking if the tablets contained quinine, as he was experiencing the first sensation of cutaneous warmth or flushing, although he had taken but one tablet. Sure enough it had inadvertently been forgotten or overlooked that the tablet contained, in addition to other ingredients, one-sixteenth grain of the salt, and this was enough to bring on an attack, which followed as a matter of course. It was in this attack that I was called in as the consultant. A few years later while the gentleman was in Paris, he ran out of his supply of tooth powder, and went into a nearby drug store to replenish. The druggist especially recommended a liquid tooth wash of his own preparation, which was

accordingly purchased. After the second toilet usage of this he had another general attack just as violent as those which had preceded it. An American physician resident in Paris was called in, and who subsequently upon inquiry discovered that the tooth wash contained an infinitesimal quantity of calisaya to give it a clean and refreshing taste. Some time after this, when in Philadelphia again, he went into the barber shop of a prominent clubhouse of which he is a member, and had his hair cut. The barber followed it with a hair tonic. While still in the chair, after the hair had been rubbed dry and combed, by a peculiar cutaneous sensation he was led to ask the barber what he had put on his scalp, stating at the same time that he felt as if he had taken a dose of quinine; to which the barber replied that it was a quinine hair tonic that he had used. Remarkable to say, and almost impossible to believe, the patient was thus brought again into another well marked attack. The application itself did not irritate, nor did the rash begin in the scalp, but the attack was the same as all the others, and presented itself in the usual manner.

Thus is outlined a part—a greater part probably—of this gentleman's curious experience with this drug. In short on many occasions his life has been made burdensome by this extreme susceptibility, against which he is not always able to protect himself, unless he eschews drinks and compound medicines of all kinds. Even then, as has been seen, he may be the victim of a dentrifice, a hair tonic or similar unsuspected and innocent looking article or preparation. He is even somewhat panicky when obliged to consult a strange physician, for in spite of his statements of his susceptibility, which he of necessity feels obliged to refer to strongly, he is not sure, but as before, the matter may be considered over-exaggerated or nonsensical, and the liberty again taken to give him at least a compound tincture of cinchona or elixir of calisaya as the basis or vehicle of the formula prescribed. The attack as I saw it, which was stated to be the same as all the others, was distinctly suggestive of scarlet fever, as the quinia rash usually is. On the first one or two days, moreover, there was slight temperature elevation, and the skin was of the bright punctiform red color. The redness subsides in from two to four or five days, and this is followed by the thin epidermal exfoliation usually observed in the scarlatinous rash. Strange to say, the patient stated to me that but a few minutes elapsed after he has taken the drug before he feels a flush go over the entire surface body, and he knows at once that the mischief has been done. His nails have always remained unaffected.

Book Reviews.

Pathologie dern blennorrhischen und venerischen Lymphgefässe Erkrankungen.

(*Pathology of Gonorrheal and Venereal Lymphangitis.*)—By G. NOBL. 155 pp. 1901: F. Dentke, Wien.

The author of this monograph discusses the pathology of inflammations of the dorsal lymph vessels of the penis, complicating diseases of the external genitals. His material was obtained at operations, such as for circumcision, the hard lymphatic cord being dissected out and studied in serial sections.

After a historical résumé, not always relevant, he refers to Biesiadecki's results in 1872, obtained by study of two cases of lymphangitis complicating chancres. In these cases the essential feature of the lesions were exfoliation of the lymphatic endothelia, fibrinous coagula in the lumen, and practically normal conditions in the vessel's walls otherwise.

Nobl describes the lymph vessels of the part, as he has studied them by injection methods, as a dorsal superficial set, a second superficial set along the raphe communicating with the former, and a deep set which begins by a fine meshwork in the glans and empties into the pelvic nodes; venereal lymphangitis attacks the first of these almost exclusively.

As the complication is noted with gonorrhea, chancre and venereal ulcers, the work falls naturally into corresponding divisions.

Gonorrheal lymphangitis occurs in 1.3 per cent. of the cases examined (2133 during five years), but persists so short a time that it may be overlooked. In the gross it appears on the dorsum as a thick, hard and reddened cord, from a knitting needle to a little finger thick, painful on erection and independently. The skin over this cord is usually not adherent to it. The microscopic findings are given in detail for eight cases. Condensed, the lesion is as follows:

The lymph vessel alone is affected, not the adjacent blood vessels; the nature of the process is partly exudative, partly productive; the endothelial lining swells, its cells proliferate and desquamate, the lumen may thus be entirely filled. The cells found, beside proliferating endothelia, are chiefly mononuclear leucocytes, with a few polynuclear and fibroblasts. Round cells infiltrate the adventitia and even the media in severe cases, coming from the nutritive capillaries of the lymph vessel. Neighboring collagen bundles may be edematous, with proliferating spindle cells. There is no tendency toward either suppuration or organization. In five out of nine cases examined for gonococci a few of these organisms were found inside the vessel. Attempts to cultivate these failed, and the plates were sterile of even pyogenic forms.

Associated with chancre similar endolymphangitis obliterans may occur, and at times there are foci of suppuration along the course of the lymphatic. Such a lymphangitis was observed in 4.7 per cent., usually about the third week after infection and before there was marked swelling of the inguinal nodes.

With venereal ulcers the lesion complicated about 3.3 per cent., and suppuration was more common than in either of the other classes.

In other words, in all three kinds of cases there is a proliferation of the lymphatic endothelia, with a peri- and para-lymphangitis if the lesion is specially

severe. With gonorrheal cases the gonococcus may sometimes be recovered from within the vessel but no pyogenic forms. In the syphilitic cases there is rather more hyperplasia of the connective tissue elements about the lymphatic, perhaps in concentric layers, and no organism is found.* With the venereal ulcer a pyogenic infection occurs and small ulcers follow destruction of the lymph vessel wall.

The monograph is not an important addition to our knowledge; it confirms Biesiadecki's results in detail; its chief interest lies in its presentation of lymphangitis in connection with acute gonorrhea, with demonstration of the coccus *in situ*; in style it is verbose and redundant.

E. H. THAYER.

Chronic Urethritis.—By KEERSMACKER and VEERHOOGEN. Translated and edited by LUDWIG WEISS, M.D. Wm. Wood & Co., New York, 1901.

This little volume is a valuable addition to our present knowledge of urethral disease. The authors follow the teachings of the Oberlaender school, and the translator has made additional notes of value covering ground not embraced by the original authors.

The main portion of the work consists of a description of the urethroscopic appearance of the urethra in health and disease, and the technique of urethroscopy and the treatment of chronic urethral disease by means of the Oberlaender or Kollmann's dilators. As these instruments apparently are coming more and more into vogue, this work will give valuable assistance to those who attempt this system of treatment; in fact these instruments, as is all urethral instrumentation, are certainly dangerous agents in the hands of unskilled operators.

One statement in the book, page 156, we cannot leave unchallenged, and that is the grounds on which coitus should be permitted to sufferers from chronic urethral disease. First it is to be allowed because if interdicted our commands would be disobeyed; second because in some patients nocturnal losses have a deplorable moral effect. Neither of these reasons seems to us to be sufficient. If our commands are disobeyed that should be done on the patient's own responsibility. As to the latter reason, it is better to teach the patient the elements of sexual hygiene and try to eradicate some of the nonsense which quack literature has instilled into the minds of many of these patients of the harmful effects of nocturnal emissions.

At the end of the book are a number of urethroscopic pictures done in color of normal and diseased types. We could wish there were more of them, especially of the posterior urethra.

Manual of Venereal Diseases. By F. R. STURGIS, M.D. Seventh edition, revised and in part rewritten by F. R. STURGIS, M.D., and FOLLEN CAROT, M.D. P. Blakiston's Son & Co., Philadelphia, 1901.

This very readable book will undoubtedly find a ready welcome among medical students and practitioners in general.

We must take issue with the writers in their treatment of suppurating bubo in which they advise early opening for evacuation of pus on the ground that if the bubo be non-virulent it is better to let it out, and if virulent the sooner it is out the better for the patient. Now, as a matter of fact, those who have made comparison in large number of cases of buboes operated upon early and

those operated upon late by a small puncture and thus evacuating the pus or allowed to open themselves, the length of time of healing is decidedly in favor of the latter class of cases. Then, too, if the bubo be virulent it is by operation converted into a large chancroid, leaving the patient a greater chance of further inoculation from the virulent pus; whereas if the bubo remains unopened there comes a time when the contained pus loses its virulency and may be safely opened by a small puncture, the cavity washed out with hydrogen peroxide and then distended with a 10 per cent. iodoform ointment, when it will rapidly go on to heal, or it may even be allowed to open spontaneously. There may be exceptions as there are to every rule laid down too absolutely; at the same time the present tendency is not to interfere too early in these cases, unless complete enucleation is attempted before the suppurative stage.

In their treatment of early syphilis the authors advise suspension of mercurials after subsidence of symptoms until a fresh outbreak makes renewal of the mercury necessary. Patients sometimes take this into their own hands by leaving treatment when symptoms have subsided and return when they have fresh exacerbations. Our own observation of cases treated by this method leads us to believe that the continuous treatment of syphilis for a much longer period by mercurials, say two years, even when no symptoms are present, is better in the majority of cases, for the reason that we have seen a majority of these cases go their entire period of treatment having absolutely no recurrence of symptoms after the first outbreak, and our belief is that these patients do best in whom this recurrence of symptoms is prevented.

The authors speak of intramuscular injections of mercurials only to mention the use of calomel by this method and are inclined to decry its use. There are cases where injections of mercury do better than any other method, and a good description of the various methods employed would have been of value.

The work is somewhat marred by a too free use of italics, in many instances entirely useless.

Simple and Chronic Specific Urethritis.—By J. HENRY DOWD, M.D. A. W. Landeittel, Buffalo, N. Y., 1901.

This small volume is valuable because the author gives us the results of his own observations in the treatment of this disease and is not padded out with a mass of material found in other text-books. It is a pity that the work is so cheaply put together and is so full of typographical errors. It is a small volume easily carried in the pocket, and contains a number of valuable hints.

G. K. S.

Society Transactions.

THE DERMATOLOGICAL SECTION AT CHELTENHAM.

(BRITISH MEDICAL ASSOCIATION.)

REVIEW BY NORMAN WALKER, M.D., F.R.C.P.ED.

(*Scottish Medical and Surgical Journal*, October, 1901.)

The principal business was the discussion of the three subjects which may be said to be most prominent at present in the dermatological mind. Sabouraud had come over from Paris to introduce the discussion on the rôle of staphylococci and streptococci in the etiology of skin diseases. In an interesting paper, read in French, but of which a full abstract was supplied to the members, he took the position that there were three varieties which played an important part in cutaneous pathology.

Streptococcic Infection.—The streptococcus of Fehleisen is the cause of the impetigo contagiosa of Tilbury Fox. This may be said to have been pretty generally accepted. Gilchrist, of Johns Hopkins, and most of the active cutaneous pathologists have verified Sabouraud's work, and in Edinburgh, too, I have found that in the majority of cases of impetigo one could get cultures more or less pure of streptococci. Unna remains an opponent of this theory, maintaining that the disease is due to a staphylococcus, and he has published several papers supporting his views.

It is certainly very remarkable that an organism so virulent as the streptococcus should be responsible for such a benign disease as impetigo, but Bullock and others have demonstrated the infinite varieties of virulence associated with this organism.

The organism second in importance according to Sabouraud is the staphylococcus aureus, which produces pustular lesions upon the skin, generally, he says perifollicular. It is responsible for a formation of boils, and, indeed, this staphylococcus may be said to be responsible for most of the purulent skin affections.

The third organism is a white coccus, for which Sabouraud suggests the name of the staphylococcus cutis communis. As it is obviously and admittedly the organism described by Welch, of Baltimore, as the *S. epidermidis albus*, it seems a pity to rechristen an already baptized child. According to Sabouraud, this organism is found in almost every skin; indeed, is the most common organism there found. It is the one which Unna has described as the *micrococcus*, and Sabouraud believes that it is responsible for all the scaly eruptions. Malassez spores (*Unna's flask bacillus*) is, according to him, only a degenerated form of this micrococcus.

Sabouraud was followed by Galloway, who held that even greater simplicity might be introduced; practically he recognized only a streptococcus and a staphylococcus, for he believes the production of color to be of only minor importance as a distinction. He regards the *S. epidermidis albus* as practically the same as the common *S. albus*, and pointed to the extraordinary variance in virulence of

the streptococcus as being much greater than that which it was necessary to assume in these staphylococci. Whitfield maintained the distinction between the *S. epidermis albus* and the *S. pyogenes albus*, the latter of which liquefies gelatine very rapidly, the former very slowly, if at all.

The determining of differences between the numerous varieties of cocci found in the skin is undoubtedly extremely difficult. While Galloway stands at the one extreme, Unna may be placed at the other in recognizing minor distinctions of color, rate of liquefaction, chemical reaction and the like as indicative of important differences in the organisms. The reactions of the skin vary so greatly in different conditions that it seems quite possible that these are associated with what may be minor, but still are important differences between different species of staphylococci. It was somewhat remarkable to note that both Sabouraud and Galloway, while dwelling on the importance of these organisms in many conditions, were both extremely anxious to make it clear that in their opinion the lesions of eczema were amicrobial.

It cannot be said that much came of the discussion beyond the acceptance of the relationship between the streptococci and impetigo contagiosa, but many ideas were suggested, and will, doubtless, form useful guides to work which may lead to more definite conclusions at the meeting next year in Manchester.

Phototherapy.—On Thursday the section was crowded to hear the discussion on the different forms of light treatment. This was introduced by Mr. Malcolm Morris, fresh, or perhaps, one should say fagged out, from his busy week as Secretary-General of the Tuberculosis Congress, who briefly put before the meeting his experience in reference to the Finsen method of treatment. He was good enough to distribute reports of an article which appeared some time ago on the subject, so that one could follow his views at leisure.

He is a firm but not rabid believer in the new method of treatment, and he showed some patients and illustrations which demonstrated even to the most sceptical the value of the treatment. The advantages of the method were, he said, its reliability, its painlessness, and the excellent cosmetic results. The disadvantages were the long time required for treatment and the expense, which I am told by one thoroughly experienced in treating large numbers of cases works out at between 6s. and 7s. per patient per day.

Mr. Morris was followed by Dr. Sequeira, who is in charge of the Light Treatment at the London Hospital, and he gave the excellent statistics of his experience, for the London Hospital has the largest installation in this country; one lamp having been presented by the Queen, one by the directors, and the third by the proprietors of the *Daily Mail*. Each of these is capable of treating four cases at a time, and thus between sixty and seventy patients are treated daily. It is unnecessary to give any further details as to their statistics, for the success of this method is admitted. What has militated against it is its enormous expense, but Dr. Sequeira demonstrated an apparatus with which they had had at least as successful results, and which was procurable at a cost within the reach of any small provincial infirmary. It is a modification of an apparatus designed by MM. Lortel and Genoud, and it is undoubtedly greatly improved by the English modification.

Finsen commenced his light treatment by using the sun, and since the sun is as rare in Copenhagen as it is in this country, he was driven to electric light as a substitute. Imitating too closely his example, he hung his imitation sun up in the middle of the room and focussed the rays down on the patient. The

French inventors place the patient and the light close together, and thus the costly and cumbersome arrangements of rock crystal lenses is dispensed with. The apparatus consists of a small arc lamp, such as is used in an electric magic lantern, which is kept cool by a constant stream of water; the whole is surrounded by a water jacket, and Dr. Sequeira has so arranged his modification of the Frenchmen's apparatus that one stream of water suffices to keep the whole cool. The extent of surface treated at a time is nearly four times as great as that treated by Finsen's apparatus, and the desired effect is produced in something like one-third of the time.

A still cheaper apparatus was shown in the exhibition by the Dowsing Radiant Heat Company, but it had not the advantage of universal mobility which Dr. Sequeira's apparatus has.

Dr. Brooke spoke on the advantages of the Finsen method, and with him apparently the limit of personal experience in this country was reached.

The discussion then drifted on to the X-ray method, or rather Dr. Sequeira concluded his remarks by a reference to it. To him belongs the credit of having, partly by accident, discovered the extraordinary effects of the X-rays in rodent ulcer. A case was sent to him by Mr. Jonathan Hutchinson, Jr., for the purpose of treatment by Finsen's method. (It should be mentioned that Finsen has treated several cases of rodent ulcer by his method.) The parts were so sore that Dr. Sequeira hesitated to use the method, and thought it well to try the effects of the X-rays as a preliminary treatment. The results were surprising, the ulcer healed up, and since then many cases have been treated in different parts of the country, and when the rays are properly applied, with invariably marked benefit. The improvement worked by this treatment almost requires to be seen to be believed, especially when one remembers that is efficacious not only in the slight cases, but also in those which are far, far beyond the reach of the surgeon.

There were present a considerable number of X-ray experts, who discussed the matter from the standpoint of the electrician. There seemed to be a general accord that hard tubes had a more excellent therapeutic effect than soft, which were more liable to cause dermatitis.

Dr. Blacker, who followed Dr. Sequeira, and who speaks with authority as an expert electrician, was extremely discreet in his praise of the method, and formed an admirable contrast to some writers who were apparently of opinion that in the X-rays has been found a panacea for each and every disease, not only of the skin but of the other organs as well. In speaking on the discussion I took occasion to point out that while a firm believer in the efficacy and usefulness of both the methods of light treatment, that their combination with the older and familiar methods was likely to be followed by much more rapid cure than when slavish devotion to the new methods excluded all other treatment.

In my own experience the rays are the most suitable treatment for the very widespread cases of lupus. They are the only treatment suitable for extensive rodent ulcer, but in more limited cases of lupus, where the appearance has to be greatly considered, then the Finsen method, with its extremely perfect scar, is to be preferred.

Seborrhea.—On Friday the discussion was on seborrhea, and was opened by Coleott Fox, who gave a historical résumé of the subject, interesting and suggestive as his communications always are. He was followed by Sabouraud, who

gave a demonstration of plates and lantern slides of his illustrative views on the subject.

He defines seborrhea as a hypersecretion of the sebaceous glands, and he believes this to be due to the growth of a specific bacillus, which may be found in very large quantities in the little greasy plugs to be found in the mouths of the glands. He says: "Seborrhea (in its etymological sense—flow of sebum) is the hypersecretion of the sebaceous gland. It is only this: seborrhea is never scaly, it is always and exclusively fatty."

This quotation illuminates the difficulty one had in discussing the paper. It is all very well for Sabouraud to say that other views, and he certainly did not spare some of the distinguished investigators on the subject, are incorrect, but by taking back the word to its etymological sense, he begs the whole question. These other observers may be wrong, but it still remains the fact that the term seborrhea is commonly and generally applied to the scaly eruption on the scalp which is known as dandruff, and when Sabouraud says that Unna is wrong in attributing any importance to his morococcus as a cause of seborrhea, and in another place that the *S. cutis communis*, which he believes to be Unna's morococcus, is the cause of all scaly eruptions, it would seem that they are not so very far apart after all.

Leaving aside names for the moment one may briefly summarize Sabouraud's views as follows: that there is a minute bacillus, which growing in the mouths of the sebaceous glands stimulates them to produce an abnormally fluid secretion. In severer cases the mouth of the gland is plugged, and we have the disease known as acne, and he believes that all forms of acne are due to this organism, plus, in the suppurating cases, the staphylococcus aureus.

Unna, on the other hand, regards the morococcus as the principal pathogenic agent, and seeing its power of producing scaling, admitted by Sabouraud, which is, after all, a mild form of inflammation, it seems a likely enough candidate for the honor of being the cause of the disease.

Cultivation of this organism of Sabouraud's is difficult. In many efforts I have only once succeeded in getting a colony in any way resembling those he demonstrated at Cheltenham, but as he was good enough to give me a couple of his tubes I trust to be more fortunate in future. They require an acid medium, and the growth is of a dirty red color.

The whole subject requires elucidation. Until authors are agreed as to the meanings to be attached to a particular name, it is obviously useless discussing it. Sabouraud's seborrhea ends in acne, Unna's in psoriasis, and it would surely be well to have as hard and fast a line as possible drawn between two such obviously dissimilar diseases.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY.

*Wednesday Evening, October 16, 1901.*W. K. OTIS, M.D., *Chairman.***Nephrectomy for Multiple Renal Calculi.**

DR. JOHNSON.—Mr. Chairman and Gentlemen of the Section: The first patient whom I show to you is a young man 19 years of age, who came under my care on the 14th day of August of this year.

During the past five years he had suffered from very characteristic symptoms pointing to a stone in the left kidney. He had had frequent attacks of severe renal colic on that side. His urine had been constantly purulent and on several occasions he had passed small calculi by the urethra.

At the time of his admission to the hospital he was suffering from a moderate daily rise of temperature of a mild septic type. His general health had suffered considerably; he had more or less constant pain and soreness in the region of the left kidney and on the day before I operated on him he passed two small renal calculi. There was tenderness on pressure over the left kidney and the organ was perceptibly enlarged. Several X-ray pictures which were taken in the hospital showed the presence of at least two large calculi in the left kidney. The operation of nephrectomy was done on August 19th.

The incision used was made parallel to the free border of the ribs and an inch below that line, beginning at the outer border of the right rectus muscle and extending outward as far as the outer border of the erector spinae. This incision possesses certain advantages. The exposure of the pedicle of the kidney in front is such that the vessels can be ligated under the control of the eye by means of ligatures of catgut passed with an aneurism needle.

This can be accomplished early in the operation and the subsequent enucleation of the kidney can then be done in most cases with very little loss of blood.

If desired, a small or large opening may be made in the peritoneum in front and the other kidney examined with the fingers and its size and consistency determined, or its absence noted. If desirable the nephrectomy may be made intra-peritoneal.

The dependant portion of the wound forms an excellent avenue for drainage. Through this cut also the ureter may be removed with ease as far down as the brim of the pelvis.

Upon exposing this kidney it was found to be notably enlarged. The secreting substance of the organ was almost entirely gone. The mass consisted of a thick walled sack, thinned out over certain areas to the thickness of blotting paper.

The contents of the sack could be felt to consist of two large calculi and of two or more tablespoonsful of smaller stones, which subsequent examination showed to vary in size from that of a buckshot to fine granular detritus.

The enucleation of the kidney was not difficult, but an anomalous vessel which entered the organ at its upper pole bled actively and required a separate ligature.

The wound was closed, except at the posterior angle, where a mass of sterile gauze was inserted for drainage.

As you see, the remainder of the wound healed per primam. The patient's

convalescence was rapidly established and at present, after two months, he is in good health. His urine is almost entirely free from abnormal ingredients; his abdominal wall is firm; he is not obliged to wear a belt, hernia being very rare after incisions in this situation.

Acute Suppurative Pyelo-Nephritis. Nephrectomy.—A. B. JOHNSON, M.D.

The patient to whom this kidney which I show you belonged was, I am sorry to state, unable to be present this evening on account of the illness of one of her children, but with the permission of the Society I will relate the history of the case and exhibit the specimen.

I saw her first on the 9th day of August of this year. She is 28 years of age and the mother of six children. Her last child was born 17 days before she came under my care. The labor was normal but retention of urine followed, and a catheter was passed on several occasions by her physician. A sharp attack of cystitis came on within a few days and was followed almost at once by pain and tenderness in the region of the left kidney. Severe constitutional symptoms also accompanied this pain—prostration, chills, fever and sweating.

When first seen by me on August 9th she appeared to be very ill. Her temperature was 105° Fahr.; her pulse 130.

The pelvic organs appeared to be normal on palpation; there was rigidity of the muscles and exquisite tenderness in the left hypochondrium.

These signs were absent upon the right side.

Her urine contained a few pus and blood cells and a small amount of albumen; otherwise normal. There was a leucocytosis of 20,000.

Her kidney was removed upon the following day. Under ether the enlarged lower pole of the left kidney could be felt.

It was removed by an incision parallel with the ribs, as in the other case.

Palpation of the opposite kidney through an incision into the peritoneum was negative. The left kidney was removed without difficulty. The loss of blood was trifling in amount. The wound was closed by sutures except at the posterior end, where gauze was inserted for drainage. Shock was not noticeable. The patient's temperature fell from 105.2 at the time of the operation steadily to 99, which was reached on the third day. Her convalescence was not interrupted by any untoward symptoms. The kidney, removed, showed the following lesions.

The organ was moderately enlarged, the enlargement being confined to the lower half, with one or two small rounded swellings visible on the surface of the organ near the upper pole. Over the swollen portion the surface was rough and of a light grayish color, showing scattered numerous yellowish white areas varying in size from the head of a pin to that of a number 5 bird shot.

Upon section the swollen and infiltrated areas were seen to contain very numerous minute foci of purulent infiltration corresponding in size to the yellowish white areas visible upon the uncut surface. From these infiltrated areas fine yellowish streaks could be traced running toward and into the pelvis of the kidney. The surface of the mucous membrane of the pelvis and the ureter did not appear to be markedly inflamed upon gross inspection.

The remainder of the parenchyma of the organ appeared to be in the condition of acute nephritis.

There were no broken-down areas of macroscopic size.

The condition of acute suppurative pyelo-nephritis as an ascending infection from the bladder is unfortunately only too frequent; but it does not often happen

that we have the opportunity to operate upon a kidney at this early stage. In my own experience I recall no other similar case in which operation was done at so early a stage of the disease, and in making inquiries among my surgical acquaintances who have had considerable experience in the surgery of the kidney I find that in their experience also such cases are uncommon.

This woman's condition was grave. Had the operation been delayed until abscess formation had rendered nephrotomy practicable the chances of recovery from the profound septicemia already existing would have rendered her recovery extremely doubtful.

DISCUSSION ON DR. JOHNSON'S CASES.

DR. GUITERAS.—Both of Dr. Johnson's cases are very interesting. In the first case, the patient from whom he removed the kidney on account of nephrolithiasis. I would say that I think as a rule, if a kidney is not much destroyed by a calculus, it is better to do nephrotomy than nephrectomy. My reason for this is because renal calculus is usually due to a diathesis, and if a stone is formed in one kidney similar conditions may give rise to one in the other kidney. I do not doubt, however, that in the patient presented by Dr. Johnson the kidney tissue was sufficiently destroyed to warrant a nephrectomy. The incision in this case, as marked by the scar, transversely around one side of the body, is rather longer than is usually required, and if we make such an incision without knowing just the condition of the kidney that we are to find, and after exposing it see that it is a case for nephrotomy, rather than for nephrectomy, we may possibly feel that we have more tissue than we care to expose to the infection coming from the kidney, and besides we run a greater risk of cutting the peritoneum and allowing infection to enter its cavity than in the ordinary incision in the line of the rib, or extending from the rib downwards and curving a little to the outer side.

The specimen of the kidney taken from the patient suffering from pyelonephritis, which Dr. Johnson showed, brings to my mind some cases that I have recently had under observation. The first case was that of a woman with pus in her urine, renal elements and pain in her right lumbar region, who had been running a temperature for some time before entering the hospital. I operated upon her and removed a kidney full of multiple abscesses, which I presented to the Genito-Urinary Society. Some of these abscesses were surrounded by so much inflammatory tissue that they resembled other conditions, and some of the gentlemen present thought that they might be gummata of the kidney. It was, however, a case of pyelo-nephritis, due to an ascending infection, similar to the case referred to by Dr. Johnson.

Another similar case was that of a woman whom I was called to see just after childbirth, and was operated upon by me a few weeks ago. She was running a septic temperature, her urine contained pus and renal elements and the kidney was markedly enlarged on the right side, extending down toward the iliac fossa. On the way to the hospital she sank into a collapse, and on entering had a temperature of 105+ and a pulse of 150. The kidney had ruptured during the journey. I operated upon her on the following day and found the ruptured cavity. The pulse and temperature then dropped. In a few days, however, they went up again, and I found that she had abscess of the broad ligament on the same side, which I opened and drained, and yet the temperature continued elevated. I then removed the kidney, and although I had needled the kidney, palpated it, and

probed the cavity from which the pus had been evacuated, and could feel no stone, after its removal I found a stone present, and a connection between the abscess cavity in the first instance and the cavity containing the stone, which was so tortuous that I had to bend my probe to enable me to pass it from the cavity and feel the stone. The patient died later on of sepsis.

I have recently had under treatment a man who was sent to me with the diagnosis of stone in the right kidney. He had all the symptoms of nephrolithiasis on the right side, a marked phosphaturia, and at times phosphatic casts of the calyces of the kidneys. He had blood and pus in the urine, pain in the right loin, although he had never had any attacks of renal colic. The urine contained gonococci, and to ascertain if these were from an infection in the urethra or bladder or higher up, I catheterized the ureters and found that the urine coming from the kidneys also contained this micro-organism. The patient was mildly septic and has, I believe, an ascending pyelonephritis and I expect to be able to present his kidney here later. His last attack of urethritis was 14 years ago.

DR. HOWARD LILIENTHAL.—I congratulate Dr. Johnson on the management of the first case and must differ from Dr. Guiteras in the indication. It seems to me that in that particular instance nephrectomy was a wise thing to do, because it was a chronic disease with numerous stones present. The kidney was thinned in some places to the thickness of blotting paper. And surely, too, the operation could be done very much more easily and safely as a primary procedure than at a secondary operation.

The X-ray pictures are remarkably good.

As to the second case I am a little in the dark as to why Dr. Johnson did not perform simple primary nephrotomy. He admits that he could not be certain that the other kidney was not infected. The fact that it was not tender or painful is of little or no significance. It seems to me, also, that one or more pretty free incisions into the inflamed organ might have been conservative and that Dr. Johnson would possibly still have had time within the next two or three days to take out the kidney in case the patient was not doing well. As it was, he took a pretty large risk in removing the kidney primarily.

I reported a case at the Surgical Society five years ago, which will be found recorded in full in the *Annals of Surgery* of about that date, in which there were multiple abscesses of both kidneys secondary to an erysipelas of the face. The patient got well after repeated openings of these small abscesses and got well without nephrectomy on either side. The man has remained well.

DR. JOHNSON.—In regard to the criticism of this incision parallel to the ribs I have already explained why it is preferred by certain surgeons, including myself, to incisions made in other ways. I did not regard it as safe to catheterize the ureters of this woman for fear of carrying infection to the other kidney, nor should I do so in another similar case. I do not regard catheterization of the ureters in cases of such acute infection as an entirely harmless procedure by any manner of means.

I did not incise the woman's kidney merely because her condition after such an incision would have been but little better than before the operation.

There was no abscess to evacuate and the source of poisoning from which she suffered could only be removed by taking out the entire organ, and it appears to me that the result obtained entirely justifies me in this conclusion.

In the case of the young man the kidney which contained the stones had

long ceased to exercise any useful function. Its prompt removal spared him a prolonged and tedious convalescence, a very possible failure of wound healing in the end, together with the great dangers and difficulties which almost always accompany secondary nephrectomies in these cases.

The Diagnosis and Treatment of Prostatic Hypertrophy, with Remarks on Complications Before and After Operation.—By RAMON GUITERAS, M.D., New York.

The author reviews in detail the symptomatology of prostatic hypertrophy, with special reference to that phase of the clinical history when the patient seeks surgical relief, when the pain and spasm and the frequency of urination become troublesome. In speaking of the diagnosis of prostatic hypertrophy he emphasizes the possibility of the presence of an elongated prostatic urethra without much enlargement of the prostate as felt by rectum, the hypertrophy growing upward and backward, and making the vesical base of the gland higher up than the rectal. Increased length of the prostatic urethra is measured clinically by determining the length of catheter which must be passed in order to draw off urine, the normal being eight inches. The length of the urethra may also be determined by a stone searcher introduced into the bladder with its beak downward.

Examination of the urine is very important in these cases, as it gives a clue to the existence of cystitis and of affections of the kidneys which are of importance when balancing the advisability for operation. It is necessary in doubtful cases to test the capacity of both kidneys by ureteral catheterization, followed by the examination of the urine from each kidney. Operations are contraindicated when renal lesions other than transient exist.

The complications influencing the patient to seek the operation are chiefly epididymitis, hamaturia, and urethral fever.

Stricture of the urethra is rare in prostatic age, and the symptoms in such cases are usually due to the prostatic-urethral impediment. Valvular lesions of the heart and fatty heart may be present. They are not complications, but must be considered in weighing the possibility of an operation. The operation may be borne well if there is compensatory hypertrophy with a valvular lesion. An involved bladder, it must be remembered, does not count as much against operation as involved kidneys, as the former can be restored to comparative health by palliative preparatory treatment before the operation.

This preparatory treatment need take but little time if the bladder and kidneys are in good condition and if there is not much residual urine, the reverse being the case if these organs are involved and if the residuum is considerable. If the patient comes with an attack of acute retention the first thing to do is to treat the attack. The urine should be drawn off gradually, not all in one catheterization, in order to prevent uremia. Not more than 16 ounces should be withdrawn at first, and at intervals of a few hours at a time about 12 ounces of urine are to be withdrawn until the bladder is empty. As a rule, a case of complete retention should have the catheter introduced 4 times daily if there are 12 ounces of residual urine, 3 times a day when 8-10 ounces are present, twice a day when 6-8 ounces are present, and once a day when below 3-6. After the bladder has been emptied in cases of retention, the catheter should be passed, at first every 4, later every 5, and afterwards every 6 hours. If cystitis be present the bladder should be irrigated twice daily with boric acid solution and once every other day with a solution of silver nitrate, and the

urinary antiseptics mentioned below should be administered. As a rule, a patient should not be operated upon until he has been broken into catheter life. If the kidneys in addition are involved, the patient should have a milk diet, diuretics, nitroglycerin, large quantities of water, and perhaps some of the urinary antiseptics, such as urotropin, salol, sodium benzoate, etc.

The patient having been thus prepared by a course of palliative treatment, is put into the best possible condition for the operation. Before the anesthetic is administered the bowels should be well cleared with an enema and the bladder washed out.

After considering the technique of the Bottini operation in a brief summary, the author then passes on to the after-treatment and the complications after prostatotomy. After the operation the catheter should be passed at intervals to see whether enough urine is secreted, if there is no spontaneous urination. If there had been complete retention before the operation, the best way is to tie in a catheter and let it remain plugged, the plug to be withdrawn six times a day for urination. Large amounts of water should be drunk, and urotropin or salol in doses of gr. x t.i.d. should be given. In addition, at the end of 24 hours, if the quantity of urine be small, a diuretic mixture containing potassium acetate and spirits of nitrous ether should be given three times a day. Mild hemorrhage is treated by flushing out the bladder with hot water, and severe bleeding, which is rare, must be treated by a perineal section and the introduction of a large tube around which gauze is packed. If cystitis be present after the operation it should be treated in the way indicated above. The result cannot be properly estimated until the sloughs are passed off entirely, in about four weeks after the operation.

The methods of prostatectomy devised by the author, namely, the vesico-rectal and perineo-pre-vesical are then described. The vesico-rectal method begins with a suprapubic cystotomy, after which the index finger of the right hand is introduced into the bladder, while that of the left palpates the prostate from the rectum. A pair of sharp-pointed scissors is then introduced into the bladder, and the capsule of the prostate is incised. The gland is now enucleated with the finger, and the floor of the urethra incised to prevent the formation of a pocket. An external urethrotomy is next performed and drainage established through a tube inserted into the bladder, the latter being sewn up tightly to the drain. This is the quickest way to perform prostatectomy. The perineo-prevesical method consists in making an incision suprapubically and making pressure upon the prostate through the unopened bladder, while the prostate is enucleated with the index finger after incising the capsule with a pair of scissors through an external perineal urethrotomy wound.

Perineal drainage is established after the operation, the skin and fascia being sewn close to the tube. This is the safest method of prostatectomy yet devised. After prostatectomy the patient should be stimulated, and given saline enemata. During the operation there is a great deal of shock, and the author has noticed that there seems to be a climax of shock at the moment when the prostate is removed. It is best to anticipate shock and to administer stimulants, etc., before it comes on. Very hot water irrigated into the hollow where the prostate has been will usually stop the bleeding. If not, the drainage tubes should be carefully packed around with gauze. After prostatectomy, as well as after prostatotomy, it is important to keep the kidneys active by means of diuretics, plenty of water, etc.

The drainage should be carefully watched, and if found insufficient, the bladder should be flushed out from below. The perineal drain should remain in situ for three weeks, after which a retained catheter should be passed into the urethra, to remain probably until the perineal wound has closed. A temperature indicates, when present after an operation, that the drainage is insufficient, or that infection has taken place. In such cases it is best to use urinary antiseptics, to wash out the bladder, and to look after the drains, and to employ general treatment. Epididymitis is sometimes a complication of these operations, and should be treated in the ordinary way, care being taken to treat the cause,—the insufficient drainage and infectious urine. Neurasthenia sometimes follows the removal of the prostate, and can be compared to the change of life in women.

The indications for operation, especially the choice of the operation are influenced by a series of clinical factors, which are exhibited in the following table: Under the heading "Catheter Life" are grouped those factors whose presence would incline the surgeon to select palliative treatment for his patient.

FACTORS GOVERNING THE CHOICE OF TREATMENT.

INDICATION.	PROSTATECTOMY.	PROSTATOTOMY.	CATHETER LIFE.
1. Age.....	Under 70 years.....	Any age over 50.....	Any age over 50.
2. Kidneys.....	Normal.....	Fairly healthy.....	Considerably diseased.
3. Bladder.....	Fairly healthy.....	Fairly healthy.....	Atonic.
4. Prostate.....	Markedly enlarged as felt by rectum.	Moderately enlarged as felt by rectum.	Any size.
5. Urethra.....	Decided impediment. Elongation of canal.	Distinct impediment.....	Catheter passed without difficulty or complication.
6. Residual Urine.....	Over 4 ounces.....	Same.....	Same.
7. Special Symptoms.....	Frequency in urination. Pain, tenesmus, burning.	Same.....	Same. Heart feeble and arteries diseased.
8. Complications.....	Attacks of urethral fever, epididymitis and hæmaturia. (Kidneys normal.	Same, but kidneys only fairly healthy.	Same, but kidneys too much diseased for operative procedure.

The results of each operation upon the prostate are next compared. The author found that the figures collected by him show in 753 cases 622 cures, 44 deaths, and 87 failures with prostatotomy (Freudenberg), and that with prostatectomy there were in 152 cases collected by the author 121 recoveries, including cures, successes, recoveries, good results, and improvement, as the case may be, according to the term used by the author reporting the case, 25 deaths, and 6 failures. In other words there were in prostatotomy 86 per cent. cures, $5\frac{2}{3}$ per cent. deaths, and 11 per cent. failures, while in prostatectomy there were 79 per cent. cured and improved, $16\frac{1}{2}$ per cent. deaths, and 3 per cent. failures. The mortality of prostatectomy is therefore three times as great as that of prostatotomy, but in those that survive the results are more frequently successful. The results of prostatectomy are also more permanent and satisfactory than those of prostatotomy. If we obtain a relief of the symptoms and a

relief of the obstruction, leaving perhaps one-half ounce of residual urine, the patient may be considered cured from the surgical standpoint.

The author summarizes the whole subject in the following conclusions:

1. That the general practitioner should be educated to palpate the prostate and to use the other simple means of diagnosis employed in determining the shape and size of the organ.
2. That the prostate corresponds to the uterus in the female, pathologically speaking, and therefore the examination of the male organ is just as important as that of the uterus in the female.
3. The care of the bladder in prostatics is the prime factor in their preparation for operation. The patients should be trained before such operations to observe the details of catheter life, and the urine and bladder as well as the kidneys should be rendered as normal as possible, before the operation is attempted.
4. Before every prostatic operation the patient should be thoroughly examined, including an examination of the heart, arteries, urine, bladder, urethra, and kidneys.
5. The successful cases belong most frequently to the class having a smaller amount of residual urine and a moderate prostatic enlargement, and early diagnosis, and operation if necessary, are the best plans.
6. That the choice of the operation should be made according to the lines laid down in the present article; according to the age, the resisting power of the patient, and the size and shape of his prostate, with special reference to the situation of the hypertrophy, together with the condition of his kidneys and bladder.
7. In the conduct of the operations the first object is to avoid shock and to prevent congestion of the kidneys by precautions during, and the proper treatment after, the operation.

DISCUSSION.

DR. FERD. C. VALENTINE.—It is regrettable that so important a subject could be presented only in synopsis. Still the author is to be congratulated on his ability to give in the short time permissible so exhaustive a sketch from the vast library that constitutes our present knowledge of prostatic enlargement. No doubt he counted upon the discussion to bring out many of the points whose omission is compelled by the necessary brevity of his paper. Among these is his sketch of the symptoms. He mentions only spasm and frequency of urination. It is perfectly true that these are the symptoms which bring the patient to the operator, but unfortunately, when these manifestations have arisen, the condition is often associated with involvement of the higher urinary tract. On the other hand, but few, if any, patients would consider operative measures when the first symptoms of prostatic enlargement arise. Delay in starting the stream, reduction of projectile length, diminution of its parabola, nocturnal urination unless very frequent, and even incomplete evacuation of the bladder, as they develop gradually habituate patients to this infirmity, so slowly that they hardly look upon it as a disease for which to seek relief. When, however, the catheter, for any reason, ceases to be useful or safe, then operative measures are certainly required.

It would have been exceedingly satisfactory if the author could have incorporated into his paper his views in extenso on the precise indications for the various operations employed for the cure of prostatic obstruction.

His description of enucleation makes the operation appear exceedingly simple. Those who have been fortunate enough to witness his performance thereof are certainly convinced that it is simple—in the hands of so skilled an operator as the author is.

A word about the author's plan of treating urinary retention: He, like all others engaged in special work, often has cause to regret that the operation is not performed with the precautions absolutely necessary to avoid the disastrous results of sudden emptying, even when the catheter is most skilfully passed. Among the results the one most to be dreaded is vesical hemorrhage *ex vacuo*. While I repeat his warning to emphasize it, I do not fully agree with his method. By his plan of gradually emptying the bladder he leaves possibly infected urine in the viscus for hours. Even in a normal bladder the risk of injury by the presence of abnormal quantities of urine is too great to incur.

The plan I follow in all vesical retentions has in view removal of all the urine as quickly as possible, without allowing the bladder to collapse and without sudden contraction. This is accomplished by withdrawing 60 c.c. of urine and injecting 30 c.c. of warm boric acid solution; then allowing 60 c.c. to escape and again injecting 30 c.c. of boric acid solution. This process is repeated until absolutely nothing but clear boric acid solution flows from the catheter. A small quantity of boric acid solution is left in the bladder, which has been thoroughly, albeit so gradually emptied of urine that no violence is done it.

DR. HOWARD LILIENTHAL.—I have been forestalled by Dr. Valentine in what I wanted to say concerning the evacuation of an over-distended bladder. Most cases of cystitis depending on impairment of drainage may be quickly cured by emptying the bladder with the catheter every three hours, day and night, for two or three days, whether the patient feels the need of the catheterization or not. This method is, of course, only suitable to such cases as will permit the easy introduction of the instrument. Then, too, much may be accomplished in addition by the internal administration of urinary antiseptics and the ingestion of large quantities of water. Since employing this treatment I wash out comparatively rarely. Washing of the viscus may, of course, be indicated when there are large quantities of mucus which cannot be otherwise evacuated.

DR. FRED. BIERHOFF.—One symptom Dr. Guiteras has not touched upon in his very admirably arranged paper on this subject, which we may have frequently in cases of prostatic hypertrophy, especially those cases that are complicated with cystitis, and that is severe hæmaturia, which may be to such an extent that patients pass not only, as the speaker has said, urine frequently, but also clots, or blood in suspension. That occurs only, I have reason to believe, in those forms of prostatic hypertrophy in which the process is complicated with congestion, or inflammation of the mucous membrane covering the prostate, just at, or near, the vesical sphincter.

Another point is the value of cystoscopy prior to any cutting operation within the unopened bladder. Personally I believe, and that belief I have reason to know is shared by Freudenberg and others who do much of the Bottini, that no one is justified in doing a prostatotomy, especially a Bottini, without first having satisfied himself as to the exact contour of the parts projecting into the bladder, for the simple reason that, in order to have the maximum of result, we must know at what point of the prostate to make our incision. We find frequently that not only the median and the lateral lobes of the prostate are hypertrophied, but it often happens that the anterior lobe takes part in the process, forming a sort of tongue, projecting from the anterior side of the vesical neck, which, at times, will aid in obstructing the outflow of urine. It is, at times, even found necessary to make an incision in this anterior lobe also.

Another point upon which, I believe, too little stress was laid was upon the

indications for operative treatment and those for non-operative. We all know a great percentage of these cases can be very decidedly improved and made exceedingly comfortable, carried along for years, without any operative treatment beyond attention to the cystitis, and other tentative, local measures.

DR. GUITERAS.—If one were to go fully into the interesting subject of prostatic hypertrophy, it would be impossible to present a paper to cover the diagnosis and operative treatment. I did not take up the consideration of the symptoms, but merely mentioned in one line the subjective symptoms which have usually brought the patient to me.

Regarding catheterization, there is, of course, no fixed rule. Patients have to be governed by the amount of residual urine and by the frequency of desire to urinate. Some men beginning to pass the catheter may have to use it every fifteen minutes, or may even have to tie it in for a few days or weeks; but the table I gave you may be considered a good average one. Cystoscopy cannot always be performed on a patient with a large prostate, as one cannot always introduce a cystoscope into the bladder. I have had patients where the end of the cystoscope would not enter further than the prostatic chamber. Afterwards having inserted a Bottini instrument into the bladder with a great deal of difficulty, and having performed prostatotomy, I have found that I could not pass the same catheter which I had used before the operation to wash out the bladder.

In one such case, in which I performed perineal section afterwards, I found that the right lobe of the prostate was very much enlarged and bulged into the prostatic urethra, forming a convexity. The left lobe, at its middle point, corresponded to the apex of the convexity on the other side, and was concave, although on either side of the convexity it bulged out into the urethra. I accordingly tried to pass my finger into the bladder through the perineal opening, having curved it. After I had passed it in a certain distance it came against the middle lobe, which formed a barrier to the entrance of the bladder, preventing me from entering. I then knew that I had been turning the end of my cystoscope in the tortuous channel or between the middle and the two lateral lobes; and, I could not possibly introduce the tip of my finger into the bladder. It is certain when your cystoscope does enter the bladder, and it usually does, that you can learn a great deal, for very often the prostate has pushed the prostatic urethra out of place and it is the only way to find out just where to make the incision.

Selections.

CUTANEOUS DISEASES AND SYPHILIS.

Impetigo Herpetiformis in Man. —F. GUNSETT (Wolff's Clinic) (*Arch. f. Derm. und Syph.*, Vol. 55, 1901, p. 337).

The author adds one case to the 27 reported to date of his article, making a total of 28 cases, 19 in pregnant or parturient women, 8 in men and one in a woman not pregnant. The writer reports another case in a woman first reported by Maret in 1887, which he does not include as a new one. This case presents this peculiarity that the disease occurred four years after the subsidence of menstruation, starting upon the thighs and spreading gradually over the whole body. She recovered from the attack. Toward the end of 1900, two years after

the last attack, she reappeared with a recurrence occupying the whole body, accompanied with high temperature. In five weeks she recovered. Thus this woman had four attacks of impetigo herpeticiformis since 1887, the first two during pregnancy (reported by Maret) the last two long after menopause (reported by the writer).

Gunsett's original case occurred in a man thirty-three years old. The disease started simultaneously on the trunk and mucous membrane of the mouth in the form of small pustules. Gradually it enveloped the breast, neck, arms, hands, forehead, nose, cheeks, scrotum, prepuce and glans penis. A temperature of 38.7 accompanied each new outbreak. Weakness and malaise were very prominent symptoms. No scars remained after the disappearance of the eruption. Recovery took place in five weeks. In considering the differential diagnosis of the disease, the writer taking into account all published cases, is of the opinion that when the following three characteristic symptoms (1) the appearance of outbreaks with chills, (2) remittent fever, and (3) general malaise; are present with the characteristic skin eruption, the diagnosis is easily established. Pregnancy is not a necessary condition for the disease. It can only be regarded as a predisposing factor. In 31 per cent. of all cases impetigo occurred in man and in non-pregnant women. The mortality, judging from all twenty-eight published cases, reaches only 52.7 per cent.

The Treatment of Two Cases of Nerve Leprosy in Which Recovery Took Place.—GEORGE THIN (*Brit. Med. Jour.*, 1901, p. 1074).

An interesting account of two cases. Recovery is attributed by the author mainly to the action of drugs. In the first case leprosy appeared when the patient was five years old. Chaulmoogra oil was applied externally and given internally for a period of nearly three years to such an extent, that the patient's system became so impregnated with it, that the linen even after being washed, the skin, and the hair smelt of it. The author had the opportunity of seeing the patient in his eleventh year—six years after the development of the disease, and then thirteen years later. The only evidence at that time of his having had leprosy was found in the mutilation of the hands and feet and in the incomplete restoration of sensation on some parts of the limbs. He suffered from no pain and his skin was everywhere normal in consistence and color and he had a fine fresh complexion. The hygienic surroundings of the patient were very good.

The second case—a healthy adolescent of a naturally good constitution—had several anesthetic spots on the face, trunk, one on the thigh, and calf.

The patient was seen during the first months of the disease and has been under care for several years. Here the treatment consisted of 5 per cent. of pyrogallie ointment being rubbed into the patches twice daily; a dram dose gurgun oil being taken twice a day and two minims of Fowler's solution twice daily. In a week the strength of the pyrogallie ointment was increased to 7½ per cent. and this was the strength which was afterwards continued. The author believes that in this instance the pyrogallie acid eradicated the small recent patches of leprosy by killing the bacilli.

An Unusual Symptom in Secondary Syphilis.—A. A. SCOT SKIRVING (*Brit. Med. Jour.*, 1901, I., p. 1077).

In the two cases mentioned by the writer, itchiness of the fauces was present during the early period of syphilis. In both cases the itchiness has appeared very

shortly after the onset of sore throat, about eight weeks after the appearance of the chancre. Marked cutaneous manifestations were present in the one, but none in the second case. In these cases the itchiness was felt most over the tonsils, and also over the pillars of the fauces and posterior part of the sides of the tongue. The other parts of the mouth and throat were not affected. It was not a nerve tickling, but a definite itchiness in every way comparable to the ordinary feeling experienced in the skin, and accompanied by a similar desire for counter irritation by scratching.

Leucoma or Leukoplakia of the Vulva and Cancer.—By H. T. BUTLIN (*Brit. Med. Jour.*, 1901, II., p. 61).

Three short reports of cases of leucoma of the vulva complicated with ulcers which were probably of a cancerous character—microscopical examination only in one case. The plaques on the vulva were precisely similar in appearance, feel, and variety of form to the white plaques which form upon the mucous surface of the mouth. The literature shows that in more than one instance, the vulva and the mouth have been attacked in the same patient presenting the same disease in both situations. If so, the influence of tobacco and of the direct contact of alcohol in the production of the disease loses some of its importance.

A Case of Lupus Vulgaris of Twelve Years' Standing, Treated with Urea and Cured.—By A. H. BUCK (*The Practitioner*, Vol. 67, 1901).

The author, acting upon Dr. Harper's advice (*Lancet*, 1901) to treat tuberculosis with urea, applied the remedy in a case of lupus, where destruction of the tissue of the face, nose and nasal cavities was very extensive. The patient has been suffering with tuberculosis of the joints and face (no microscopical examination) for years, and during one month's treatment with urea the author achieved such a result that he considers himself entitled to look upon the lupus as cured. He prescribed "pure urea" 20 gr. t. d. s. in peppermint water 1 oz. together with maltine $\frac{1}{2}$ oz. t. d. s. The ulcers were dressed with unguent. plumb. iod. The amount of urea was gradually increased until the doses reached one dr. t. d. s. There has been no bad symptom of any kind; on the contrary, the patient felt better. With this method of treatment the author believes he gets at the fons et origo mali, viz., that receptability which exists in patients who are the victims of lupus or any other tubercular disease.

Lymphangioma Circumscriptum Cutis.—HUGO SCHNABEL, (Riehl's Clinic, Leipzig.) (*Arch. f. Derm. and Syph.*, Vol. 50, 1901, p. 176.)

The twenty-three-year old patient applied to the hospital for an early syphilitic eruption, hard chancre and roseola, and upon examination, several pinhead to lentil-sized, raised, roundish (quite egg-like) disseminated efflorescences have been noticed in the second right intercostal spaces of the anterior thorax. Their consistency was glottic, resistant, and did neither disappear nor diminish on pressure. In two of the efflorescences minute bright red specks, not disappearing nor diminishing under pressure were noted. No inflammatory symptoms could be seen in the surrounding skin. On rupture a lymphatic fluid of alkaline reaction exuded from the vesicle. The affected portion was excised down to the fascia; and prepared for microscopical examination. No exudation of lymph was noticed, nor did a relapse take place. Microscopical examination revealed in the corium and subcutaneous tissues some lymph vessels and lymphatic channels clogged either entirely or partly, and with degenerated endothelial cells,

which brings about a lymph stasis, a condition tending to proliferation of the endothelium of lymph vessels. He agrees with other writers that we have had to do with a lymphangiectasia combined with a neoplastic process.

Epithelioma Adenoides Cysticum.—M. WOITERS. (Doutrelepont's Clinic) *Arch. f. Derm. und Syph.*, Vol. 56, p. 89, 1901.)

A girl of twenty suffering with gonorrhea came under the observation of the author; under the right eyelid a reddish-yellow tumor projecting slightly above the surface and passing gradually into the skin, was noticed. The tumor, as far as the patient could remember, had been present on the face since childhood, and did not cause any pain. It was removed and subjected to a very minute microscopical examination.

The author reviews critically the literature of the subject, endeavoring to solve the question of the origin of the tumor. The origin he ascribes to the epithelial layer of the skin or its appendages. Not only the epithelial layer, but the basal layer of follicles of the sebaceous glands and the interpapillary prolongations may be the points of starting of the growth.

Lupus Erythematosus in Sisters.—S. RONA (*Arch. f. Derm. und Syph.*, 56, 1901, 381.)

According to the author there are only two allusions in the literature regarding the concurrence of lupus erythematosus in one family. Therefore his two published cases can be regarded as the first examples of the disease published.

He had the two sisters affected under his observation for a long time, and thinks that a mistake in diagnosis is to be excluded. Regarding the third sister, who also suffered from an eruption, he has no fixed opinion as to the nature of her disease, and he does not regard it as lupus. The family history of the two sisters reveals tuberculosis only in one uncle. In the first sister, twenty-four years of age, the eruption occupied her left cheek and nose; in the second, twenty-eight years of age, the face and scalp exhibited characteristic efflorescences of lupus, combined with tuberculosis of the right eye and perforation of the left membrana tympani. The author gives his statistics regarding the age, the relation of lupus erythematosus to vulgaris. Lupus erythematosus is oftener met with before the age of fifty than after. One patient under his personal observation with lupus erythematosus succumbed to phthisis of the lungs; in two others there was swelling of the glands and a family history of tuberculosis. In 100 cases of lupus erythematosus, which he saw personally, he never noticed lupus vulgaris as a complication.

Multiple Spontaneous Keloids.—VLADYSLAW REISS (University of Cracow). *Arch. f. Derm. und Syph.*, 56, 1901, 323.)

Multiple spontaneous keloids are of very rare occurrence, and the case of de Amicis only can be ranged alongside with the following case of the author's. The patient was a girl of twelve. Nothing can be learned of her family or personal history. The eruption in form of hard, round rose-red tubercles began to develop in the last years, occupying symmetrically the thorax, seventy on the right side and fifty-four on the left side, the left upper extremity, forty-five and thirty-seven on the right upper extremity. Only a few tubercles were seen on the thigh, the crura being free. The tubercles were movable with the skin, of ovoid or roundish form. Over them the skin is rose-red, shining, smooth without any sign of scaling. The nodules are painless. Their sensitiveness to thermal or

tacile irritation diminished. The electrode does not produce contractile movement in the nodule. There were no signs of traumatism or breaking of the continuity of the skin. Three nodules were excised for histological examination. As the patient disappeared shortly after excision, the author cannot say whether scar-keloids appeared on the places. Histological examination revealed the complete intactness of the papillæ, the rete malphigii being normal only here and there. Stratum spinosum was slightly thinned. There was a complete absence of elastic tissue in the nodules, but an intermediary zone where elastin was noticeable, though in very slight amount, was observed by the author. The blood vessels did not show any changes.

A Contribution to Keratoma Hereditarium Palmare et Plantare.—

HANS VORNER (Richl's Clinic). (*Arch. f. Derm. u. Syph.*, 56, 1901, p. 1.)

After considering the literature of the subject, the author gives the histories of his patients. The foregoing disease affected four generations of a family. Out of forty members of the family, sixteen (40 per cent.) inherited the disease. The youngest member, a boy, fourteen weeks of age, had the disease developed on both palms and soles. Right after birth his palmar and plantar surfaces were more tender and the skin smoother than in other infants. From the second to the fourth week of life the epidermis began to show a harshness and a red zone on the borders of the palm and sole appeared. This thickening of the epidermis, in all the extremities, gradually increased, and there was never noticed a desquamation of the epidermis during childhood. The disease exhibited the same symptoms as to aspect and clinical course everywhere. It did not give rise to any inconvenience. All the patients sweat profusely on the palms and soles without exhibiting the same tendency in other portions of their bodies. He asserts that all layers of the skin of the sole are uniformly thickened, and the transformation of the rete cells into horny plates takes place as a whole in a normal manner. There is no qualitative change. There is no sign of inflammation. He looks upon the whole process as a gigantic growth of the epidermis, which corresponds with the formation of the epidermis of soles of certain animals (bear). The writer then gives a critical and minute differential diagnosis of the foregoing disease and other clinically allied affections.

A Method of Sterilizing Soft Catheters.—By HERBERT T. HERRING, M.B., B.S.

(*British Medical Journal*, May 25, 1901, page 1260).

HERRING has devised an apparatus for the rapid sterilization and lubrication (aseptically) of soft catheters. Twelve catheters may be sterilized and lubricated in twenty minutes. Water at the boiling point sterilizes the instruments and liquid paraffin at the same temperature lubricates them under absolute asepsis. A drachm of liquid paraffin thus employed will lubricate six catheters.

Boiling catheters does not injure their fabric any more than other methods of sterilization, if as much. By the method described patients living the catheter life can be assured of using sterile instruments and avoiding infection. The apparatus is fully described.

A. L. W.

Iodipin in Syphilis.—DR. R. CHERNBACH,¹ hospital physician in Husi, Roumania, reports two very severe cases of syphilis in which he used iodipin.

The first case was a woman of twenty-eight, who had deep purulent and ill-smelling ulcerations on the left cheek and on both feet. The patient was weak and emaciated and her general condition was very bad. Yellow mercurous iodide

and potassium iodide were ordered internally and the ulcers were treated locally. After eight days the mercury had to be discontinued on account of the stomatitis which made its appearance. Treatment with iodipin was then commenced. For two weeks the patient received a daily hypodermic injection of 5 cc. (75 min.) of the 25 per cent. preparation. On leaving the hospital her general condition was good.

The second case was a girl of sixteen, affected with the severest kind of cachectic and destructive syphilis. She had large ulcerations on the fauces, pharynx and tonsils. The uvula was completely destroyed. The anemia was severe. She was given yellow mercurous iodide, and the 10 per cent. iodipin was injected hypodermically in doses of 10 cc. (2½ drams). After three weeks' treatment the ulcerations in the throat were cured. The general condition was satisfactory and the anemia was improved.

The author says that (1) the injections were practically never painful; (2) the local reaction was very slight; (3) the action of the iodipin became noticeable in a very short time and in a most remarkable manner; (4) at no time did the injections cause a rise in temperature.

¹(*Medico*, May 1, 1901.)

Epidermolysis Bullosa Hereditaria, with Report of the First Case of the Disease in the Negro Race and Notes on the Blood and Vesicle Cells.—

By HENRY LEE SMITH and THOMAS R. BROWN (*Maryland Med. Jour.*, Vol. 54, 1901, p. 141).

The author's case occurred in a mulatto girl of seven years—first case recorded in the negro. The patient had been subject to the disease since her early infancy. The disease existed in her grandmother, father, brothers and one sister.

On the scalp, buttocks, abdomen, and the extensor surfaces of the forearms and legs pigmented areas were seen. Tense bullæ containing clear fluid and varying in size from a large pea to a robin's egg, were situated mainly on the feet. The exudate of the inner bullæ was slightly blood-tinged. Vesicles of smaller size were irregularly scattered over the feet and the legs.

As the excision of a bleb was refused, the writer cut out a piece of normal skin and the sections showed at intervals along the basal border of the epidermis, a grouping of irregular, deep-staining nuclei, which were surrounded by vacuolic areas. The same layer showed in other places elongated nuclei arranged in more or less confusion (Gilchrist).

The fact that general and local eosinophilia is especially likely to be associated with pemphigus and pemphigoid eruptions, was proved by Dr. Brown's examinations of the blood, not during a fresh outburst of the eruption, where he found in 11,000 leucocytes per cubic millimeter, 42 per cent. were polymorphonuclear neutrophils, 40.6 per cent. small mononuclears, 7.7 per cent. large mononuclears and transitional forms, and 9.7 per cent. eosinophiles. The blood in drying vesicles showed a number of red blood-cells, some polymorphonuclear neutrophils, and not more than 4 or 5 per cent. eosinophiles.

Subsequent Observations Regarding "Multiple Benign Sarcoid of the Skin."

—Prof. CÉSAR BOECK (Reprint, Kaposi's Festschrift: 1900)

In December, 1899, the author published in this JOURNAL a very remarkable case of the foregoing disease. In this article he describes three additional cases,

expressing the belief that "we have here to do with a certain, well characterized clinical type of disease."

The whole course of the malady is chronic. The single papules and tumors require months and sometimes years for their development and for the various typical stages of their course.

The eruptive stadium of a single efflorescence can appear under various aspects. Very often the eruption appears suddenly, the whole involved skin being red and swollen and the seat of an itching sensation. In one or two cases a distinct papule appears upon the affected skin surface. Sometimes the papule will only be felt under the swollen skin, not appearing upon the surface. This stage of redness and turgescence may last a very long time. The color of the eruption is usually at this period vivid red or bluish or brown-red and a slight desquamation takes place. After this period the regressive stages follow. Gradually the tumor flattens, changing its red color into a yellow or brownish-yellow pigmentation; this may last long and is a very characteristic phase in the course of the malady. It cannot be taken for any other disease at this time, owing to the markedly yellow or brownish-yellow discoloration. In some cases this lesion is combined with the following telangiectatic condition, when, while the periphery of the tumor is still slightly infiltrated and yellow, the central portion is depressed and penetrated by enlarged capillaries. This telangiectasis seems to be a constant symptom, although it is not always present in the same degree. Lastly, the telangiectasis disappears leaving a slightly depressed, often hardly visible, white scar.

The tumors mostly occupy the face, but also the scalp, then the neck and the extensor surfaces of the upper extremities. Upon the lower extremities, both the extensor and flexor surfaces may be involved.

In cases where the whole course of the development of the tumor takes place in the subcutaneous tissue, only a slight redness of the skin will be seen.

The disease has a special tendency to localize itself around old scars. Neither softening nor ulceration of the tumor ever occurs. The glands in some cases may be swollen.

The pathology of the malady is rather to be regarded as an inflammatory hypertrophy of the connective tissue, than as a tumor-like neoplasm. The cause of the disease is still a mystery.

Arsenical treatment, uninterruptedly followed, will give good results, although the course is very prolonged.

Syphilitic Heredity.—By S. W. MACILWAINE, L.R.C.P., M.R.C.S. (*British Medical Journal*, June 15, 1901, page 1476).

In a communication MacIlwaine reports the case of a man, aged forty-seven, who incurred syphilitic infection some twenty-five years previously. Was not efficiently treated. The primary and secondary stages gave little trouble, and until five years ago he was in robust health. At that time he was found to be suffering from aortic regurgitation, and lately mitral regurgitation has been added, dropsy has increased and complete breakdown of the heart seems imminent.

He has two sons, ten and eight years old respectively, born at full term; the mother never showed signs of infection. Both children suffered from rickets in childhood, otherwise showed no evidence of disease.

The elder boy at the age of eight, immediately began to break down, on going to preparatory school. Suffered from chilblains, lost flesh and color, became rather unstable and irresponsible mentally, and soon suffered from diurnal incontinence

of urine and later, of feces also. He was unable to bear the conditions that suited other boys of the same age.

The younger boy, at the age of six, had a very violent epileptic attack, ten days after a slight injury to his forehead as a result of a fall on a gravel path. The attack was relieved only by the administration of chloroform. For two years thereafter epileptiform attacks came on, of varying intensity and intervals, associated with marked mental and physical deterioration.

Accepting the opinion of some that both the cardiac condition of the father and the pathological condition of the sons are alike traceable to syphilis, the author asks, "what is the exact relation of the diseased condition of the sons to the infective disease of the father." He believes that the cause of the disorders from which the sons suffer is not hereditary syphilis, but syphilitic heredity. The distinction between hereditary syphilis and syphilitic heredity is of great importance, as regard prognosis and treatment, and also as bearing on the question of the transmission of syphilis to succeeding generations.

A. L. W.

The Recognition and Etiology of Hospital Gangrene.—(Neumann's Clinic).

RUDOLF MOLLENHAUER (*Arch. f. Derm. and Syph.*, 55, 1901, p. 66).

In spite of the prevalence of antiseptis, hospital gangrene still occurs in sporadic cases. Most often it is met with in the genital and anal regions. The so-called "diphtheritic" and "phagadenic" sores, which are wrongly called "gangrenous" are to be regarded as ulcers of this character, and represent the "pulpous" and "ulcerous" form. Whether the gangrene appears in the form of these two varieties depends upon the localization, and it is based upon anatomical conditions of the affected tissues.

Histologically the disease is characterized by an inflammatory process which leads to an early coagulation necrosis.

In all probability the disease is produced by an anaerobic bacillus. Although an unquestionable pure culture of that bacillus was not obtained, it is nevertheless always demonstrable in large numbers in the sections of tissue taken from the borders where the disease is spreading. The bacillus is long, straight, only occasionally slightly curved, $\frac{3}{4}$ mm. long and 0.3 to 0.4 mm. wide. The bacillus is mostly single, occasionally it is met with in twos arranged longitudinally. The ends are roundish. It is stained by Gram. The infectiousness of hospital gangrene is not so high as to require isolation. Inoculation upon human beings and animals succeeds only under special precautions.

Ioderna Tuberosum Fungoides.—O. ROSENTHAL (*Archiv. f. Derm. and Syph.*, 57, 1901, 3).

A girl of twenty-nine was affected with a tumor-like eruption, occupying mostly the left side of the face, after a prolonged administration of K. I.

From histological examinations of excised tissue, the writer concludes that we have here chiefly to do with a considerable inflammatory change of the blood vessels, namely, with an endo- and probably peri-phlebitis and arteritis. The sebaceous glands are only affected indirectly. The pigmentation associated with the eruption is due to blood diapedesis. Regarding the fungoid growth of the eruption the writer is inclined to regard secondary infection with cocci as the cause.

Occupation Dermatitis in Skin-Dyers.—(*Annal. Derm. and Syph.*, 1901, April)

L. Bracy and Ch. Audry described under the name of "pigeonneau" ulcerations occurring upon the fingers of skin-dyers as consequences of their work.

After a review of the literature of the disease they describe three cases, which were under their observation from the beginning of their development. The changes upon the skin are consequences of the corroding substances used by the workers for dyeing purposes. Insignificant abrasions, fissures or slight desquamations upon fingers resulting from constant wetting of the fingers in solutions used in dyeing, turn into ulcerations of special typical aspect. They are either of an elongate form, running in the axis of the fingers, or present round, crateriform, deep ulcerations, sometimes reaching the periosteum. The edges are infiltrated, surrounding tissues inflamed and accompanied by itching and burning. The edges are sharply cut and a dark point is often visible in the bottom of the ulceration, giving it the appearance of a bird's eye; hence the name of "rossignol" given to it by the French workmen.

Usually the ulcerations are located upon the dorsal aspect of the metacarpophalangeal joint of the left thumb, but they are seen upon other phalanges and upon other fingers. Outside of this typical appearance the ulcerations do not present any other characteristic signs which may be used for differential diagnosis.

Left untreated and in favorable surroundings for development the sores may spread to the ungual phalanges, changing the form and appearance of the nails.

The best treatment is not to expose the hands to the detrimental action of the dye. Sometimes the disease will not affect the workmen for a long period; and then suddenly with the introduction of a new basic dye the disease will appear. Workmen suffering from latent syphilis are more liable to be victims.

A Clinical and Anatomic-Pathological Contribution to the Study of Pityriasis Rubra Hebrae.—W. KOPYTOWSKI and WIELOWIEYSKI. (*Arch. f. Dermat. and Syph.*, Vol. 57, 1901, p. 33; *Gazeta Lekarska*, Vol. 21, 1901, p. 915; *Journal des Mal. Cutan. et Syph.*, Vol. 13, 1901, p. 533).

This article is published simultaneously in the three foregoing medical journals, presenting in each one of them the subject from the standpoint of the readers of each, giving in the special journals the more interesting special points of the disease, in a more elaborate, minute and detailed manner, and paying more attention to points interesting to the general practitioner in the other.

The study is based upon a history of a patient whom the writers had an opportunity to observe for a long period, and who finally succumbed to the disease. The disease lasted two years and during that period was variously diagnosed as chronic eczema, universal eczema, scabies, and accordingly treated. For the period of his being under the writer's observation Asiatic pills, carbolic acid, ol. gynecardiae, iodothyroidin have been tried with no success.

The writers in studying this case, tried to contribute some data on the question raised by Jadassohn, whether there is some connection between tuberculosis and pityriasis rubra. Jadassohn found giant cells and a few tubercle bacilli in the lymph glands. In order to prove or disprove Jadassohn's statement histological and bacteriological examination and inoculation into animals were undertaken with the following results.

For histological examination three pieces of the skin from various localities were removed during the patient's life, hardened in three different liquids, and serial sections examined. They were fortunate enough to be in a position to examine the various stages of the disease; the primary stage of papule formation;

the middle stage; the confluence of the papules and formation of diffuse inflammatory patches; and the last stage, the degeneration (Entartung) of the skin.

The most important feature in the histological findings was the presence of giant cells in the cutis, nearly always in the center of the inflammatory focus, single or sometimes in groups. Outside of giant cells epithelioid cells in clusters of three, four, five could be seen. Many transitory groups of cells were seen, allowing the authors to draw the conclusion that the giant cells developed from the epithelial cells. (?Ed.) No tubercle bacilli were found in the sections, which contained the giant cells.

Numbers of cocci were found in the cutis, especially the lower layers of the cutis. The cocci were not decolorized either by Gram or Weigert methods. In order to determine the rôle of the cocci pure cultures were obtained from the parenchyma of the living skin, showing diplococci, sometimes tetrads, not decolorized either by Gram or Weigert. Animal inoculations of pure cultures were not followed by any unfavorable results.

In order to corroborate Jadassohn's observation (tubercle bacilli in lymph glands of patient dead of pityriasis rubra) animal—guinea-pig—inoculations were undertaken. Pieces of skin taken from the patient during life were inoculated into the animals, and no tuberculosis developed in any of them.

The post-mortem examination of the patient revealed a croupous pneumonia, mixed, mostly parenchymatous nephritis, chronic fibrous and in some portions verrucous endocarditis and edema of the meninges. In portions of the skin taken after death parasites—cocci—were found. The writers are inclined to ascribe to the presence of the parasites in the skin during life and after death, an important rôle in the causation of the disease.

Coloring Matter Produced by Pediculus Pubis.—MORITZ OFFENHEIM. (*Arch. für Derm. and Syph.*, 57, 1901, 235).

Since the experiments of Deiguet and Mallet the maculæ ceruleæ, formed upon the human body in the presence of pediculus pubis, have been regarded as the result of a toxic erythema produced by the secretion of the salivary glands of the pediculus, which enters the skin during the bite. Although the maculæ never exhibit any redness or edema, although the steel-greyish color does not undergo the chromatic changes of blood extravasation, the foregoing view was nevertheless accepted. Oppenheimer examining the pediculus found that in its body there exists a green coloring substance like the coloring matter of the blue spots.

From chemical examinations he concludes that there is a certain similarity, although not an identity of the coloring matter with biliverdin and explains the formation of the coloring matter as follows:

The cells of the liver produce the pigment of bile within the human body. In the same manner the pediculus produces out of the hemoglobin of the human blood the foregoing green coloring substances, by means of a ferment present in its salivary glands. Of the salivary glands the pediculus has two pairs adjoining the stomach, both opening at the sides of the mandibles. During biting the ferment contained in the salivary glands is deposited under the skin and coming in contact with the human blood produces a green pigment substance, free from iron, which being finely scattered under the epidermis takes a steel-blue color. It does not undergo chromatic changes and retains its bluish tint till its absorption.

The pediculi of scalp and garments have no such power, and not all pediculi

pubis have the faculty of producing this coloring substance. According to the writer twenty per cent. of them do not exhibit traces of it.

Histology of an Induration Due to Injections of Calomel Administered Three Years Ago.—CH. AUDRY. (*Jour. d. Mal. Cut. et Syph.*, 13, 1901, 373).

A man of forty suffering with syphilis received a series of calomel injections. Three years later he was admitted to the hospital with syphilitic leucoplasia of the tongue and pulmonary tuberculosis in the cavernous stage. In his buttocks there was an induration which was painful in humid weather. The post-mortem examination revealed in the place of induration a white round string, 0.015 cm. in diameter, covered with muscular fibers, exhibiting here and there a number of round cavities, giving to the cord the aspect of a sponge. In sections the cavities represented canaliculi of 0.005 to 0.01 in length, blind at their ends and not anastomosing. From microscopical examination the writer concludes that he had to do here with an old interstitial myositis ending in new connective tissue formation. There is no doubt that the inflammatory proliferative and degenerative process had its seat in the interfascicular connective tissue, and that the sarcolemma does not play any part in that process; it is destroyed like the rest of the muscular fibers. The cavities were probably determined by the initial injections. Not the slightest trace of any infectious process or of mercury was found.

GENITO-URINARY DISEASES.

Sterilization of Catheters.—*Med. Standard*, 1901, p. 273.

Through the efforts of Dr. M. Claudius of Copenhagen it seems that we finally have a sure and reliable method by which we can secure a perfect sterilization of catheters. The question at issue is treated briefly in *Hospitaltidende* No. 10-19, 1901. Boiling of catheters in ordinary water is a universally used method and has been employed since these instruments were invented and sterilization by boiling accepted by the profession. However, it is a fact, which is coming up for discussion by all bacteriologists, that boiling in plain water does not *per se* insure sterilization of catheters. Time and again have germs been cultivated from catheters which have been boiled for hours in plain water. Dr. Claudius has experimented with this problem and proved that silk catheters, which were rubbed vigorously with virulent cultures of streptococci, staphylococci, anthrax and other pathogenic germs and allowed to dry, would show cultures time and again, when boiled in plain water even for hours.

He then boiled these infected catheters in different solutions and tried to obtain cultures from them, at the same time observing how much damage was wrought to the catheters. He found that boiling in a concentrated salt solution not only did not spoil the instruments but did kill the pathogenic germs; furthermore, that a boiling of from five to ten minutes was all the time required. A question raised by many is this: Should the catheter at any time during the process of sterilization be in contact with the walls of the vessel in which it is boiled and would this result in a burning of the catheter? To this the doctor replies that if a thermometer is laid on the bottom of the vessel, even directly, over the point against which the flame is directed, the thermometer will only show an increase of temperature of $\frac{1}{2}^{\circ}$ to 1° . Even when the catheter or thermometer is enveloped in a cloth or otherwise prevented from touching the vessel

at any point, the result will be the same. It will thus be seen, that there is no difference whether the catheters are boiled in water or saturated salt solution, when the question of burning them against the sides of the "vessel" is at issue.

The point in this new method is this: By boiling in saturated salt solution, the catheters are exposed to a temperature of 110° C in a highly bactericidal medium. As said before, germs may retain their vitality and virulency by being boiled for hours in plain water; while they are *always killed* by being boiled in concentrated salt solution in the short space of from five to ten minutes. Boiling in the salt solution compared with boiling in plain water has its parallel in the autoclave at 120° C, compared with sterilization by steam at 100° C.

A Fatal Case of Hematoporphyrinuria.—By HENRY WALDO, M.D., M.R.C.P.
(*British Med'l. Journal*, June 15, 1901, page 1473).

A male patient, aged thirty-three, had taken various hypnotics, chiefly sulfonal, to induce sleep. Suffered from dyspepsia and giddiness.

Was taken with pain and tenderness over the stomach, attended with nausea, vomiting and constipation. Was slightly delirious at night and gradually passed into a condition resembling delirium tremens. The gastritis then passed off and in ten days he was able to take a fair amount of food per mouth. A few days after the onset of his illness, it was noticed that his urine resembled port wine in appearance, and smelt like chlorodyne, while another specimen smelt like celery.

When examined the urine contained no albumen and the guaiacum test gave no sign of blood. The microscope showed only a few crystals of uric acid. The spectroscope showed bands corresponding to those produced by hematoporphyrin.

The pulse rose from 80 at the beginning of his illness to 180 per minute. Patient became tremulous, restless and violent, and this condition was succeeded by general paresis in which the sphincters participated. Temperature varied from 99° to 104° . Four days before death, convulsions of an epileptic character occurred and continued to the end. No urine was passed for forty-eight hours and the bladder appeared to be empty. No headache appeared through all the illness, which consisted of ten days of symptoms of acute gastric irritation, and two weeks with cerebrospinal symptoms and progressive toxic paresis. No post-mortem could be obtained.

In these cases the symptoms are said to depend not so much on the action of the sulfonal itself as on chemical changes almost certainly alimentary in the first place, and probably hepatic, of which the drug has been the exciting cause.

A. L. W.

On Nephrorrhaphy with Flap Fixation.—By A. STURMDOFF, M.D. (*Medical Record*, June 12, 1901, page 998).

STURMDOFF describes a plan of procedure which he has devised, by which the loose kidney is fastened to the parietes. Two flaps are formed with blunt-pointed scissors by the slitting the capsule laterally at each end of a longitudinal incision.

Longitudinal slits, corresponding in location and length to the position and width of the fibrous capsular flaps, are next made through the adjacent muscular tissue, and the flaps drawn through these slits secured in place by a running suture of fine chromicized catgut. The final suture includes skin, fat and fascia; primary union follows, the sutures being removed on the eighth day.

The permanence of the result is guaranteed in proportion to the integrity of the capsular flap; for by this method are obtained not only all the advantages of

cicatricial adhesion, but in addition, the effectual retention secured by what might be called an artificial suspensory ligament.

A. L. W.

The Bacteriology of Cystitis, Pyelitis and Pyelonephritis in Women, with a Consideration of the Accessory Etiological Factors in These Conditions, and of the Various Chemical and Microscopical Questions Involved. —By THOMAS R. BROWN, M.D. (*Johns Hopkins Hospital Reports*, Vol. X., Nos. 1 and 2, 1901.

In a very lengthy and exhaustive article, the author discusses this subject in great detail. One hundred cases were carefully studied, the cases being distributed as follows: Acute cystitis, 26; chronic cystitis (alone, 24; associated with pyelitis and pyelonephritis, 7), 31; tuberculous cystitis (alone, 2; associated with pyelitis and pyelonephritis, 4), 6; cases with symptoms suggestive of cystitis, but with no infection (due to urinary hyperacidity, 9; due to other causes, 8), 17; acute pyelonephritis and pyelitis, 2; chronic pyelonephritis and pyelitis (alone, 4; associated with cystitis, 8), 12; tuberculous pyelitis and pyelonephrosis (alone, 2; associated with cystitis, 4), 6.

Many of the cases were post-operative and could be carefully studied before, during and after the infection. In all the cases of renal infection the urine was obtained directly from the kidney by catheterization of the ureters, and a careful cystoscopic examination was made in all the chronic cases and most of the acute ones, so that no possible mistake could arise in the diagnosis of the condition. The conclusions arrived at are as follows:

1. The direct cause of the infection of the urinary tract in women is the invasion and multiplication of some form of micro-organism. 2. The most common cause of these infections is the *B. coli communis*, which a consideration of the cases of acute cystitis definitely proves can and does in a large number of cases set up a true infection without the aid of any other micro-organism.

3. Marked variations are seen in the virulence of this micro-organism and in its pyogenic properties.

4. Other micro-organisms frequently found are the tubercle bacilli, various staphylococci and the *B. proteus vulgaris*; while numerous varieties of micro-organisms have been less frequently and occasionally met with, as the *B. pyocyaneus* and typhoid bacillus.

5. The proportion of cases of infection due to the *B. coli communis* is greater in women than in men, probably due to the close proximity of the female urethra to the anus.

6. Besides the entrance of the micro-organisms, other factors are in most cases essential to the development of a cystitis; the chief of these factors are anemia, malnutrition, trauma of and pressure upon the bladder, congestion of the bladder and retention of urine.

7. In cystitis the chief mode of infection is by the urethra, though one must also consider as possibilities a descending ureteral infection from an infected kidney, pyogenic metastasis by means of the blood and lymph currents, and direct transmission of the micro-organisms from the intestinal tract or from some adjacent focus of infection.

8. In pyelitis and pyelonephritis the usual modes of infection are along the ureter from an infected bladder and by means of the blood and lymph currents; in the cases studied these modes of infection were found about equally represented.

9. In the great majority of cases of cystitis, both acute and chronic, and in the majority of cases of pyelitis and pyelonephritis, the urine is acid.

10. In the cases in which the urine is ammoniacal, the infection can be produced without the aid of any of the accessory etiological factors mentioned above, the irritation of the ammoniacal urine apparently being sufficient to render the bladder susceptible to infection.

11. In the case of infections of the kidney due to a urea-decomposing micro-organism, a stone is very likely to be present if the case is at all chronic.

12. Certain conditions exist which present most of the symptoms of cystitis but no infection; the most difficult of which to diagnose is probably urinary hyperacidity of neuropathic origin, the successful treatment of which depends upon the successful recognition both of its urinary features and its general basis.

13. Although the diagnosis of renal infections can be made with absolute certainty only by ureteral catheterization, a probable differentiation between renal and vesical infection can be made by a careful study of the urine alone.

14. Tuberculous infections of the urinary tract frequently occur with no other demonstrable tuberculous lesions elsewhere in the body. Probably a tuberculous gland would be demonstrable post-mortem in most of these cases.

15. The colon bacillus seems to be the most common cause of pyelitis, while the *B. proteus vulgaris* and members of the staphylococcus group are also found less frequently.

16. And finally, to be able to thoroughly understand cases of cystitis, pyelitis and pyelonephritis, to make the proper diagnosis, to inaugurate and carry out a rational line of treatment and to give a correct prognosis, a careful chemical and bacteriological examination of the urine is absolutely essential.

A. L. W.

Renal Tension and Its Treatment by Surgical Means.—By REGINALD HARRISON, F.R.C.S. (read in the Surgical Section at the Annual Meeting of the British Medical Association, 1901).

Harrison advocates incision of the capsule of the kidney in cases of renal tension. He terms the operation "capsular nephrotomy," the term being intended to limit the extent of the proceeding. A number of cases are reported in which an incision into the capsule of the organ, one to two inches in length, performed on the convex border, relieved the tension and the nephritis in cases in which medical treatment had failed.

The kidney capsule is very intolerant of sudden increase of intrarenal tension and experience teaches that in certain conditions of congestion the capsule is so tightly stretched and its substance exposed to so much pressure as quite to explain any interference with its functions. The results of operation also tend to show the importance of increased tension, for sometimes after mere incision the quantity of urine excretion is doubled in twenty-four hours.

Of four cases related, one was scarlatinal nephritis, the second was nephritis from the exposure to cold and damp, the third, subacute nephritis probably following upon influenza, the fourth, nephritis complicated with an injury. All four cases were characterized, among other features, by the presence of albumen in the urine, which the author attributes to inflammation or its immediate effects. In all of these cases the cortical incision relieved the tension in quick order. Direct surgical intervention for the relief of tension is indicated also in that class of cases in which the congestion and inflammation of the kidneys are caused by irritants derived from various infectious diseases, such as scarlet fever,

diphtheria, measles, and the like, from alcohol and food intoxicants, and from the excessive use of such drugs as turpentine and cantharides.

The author calls attention to the fact that the relief of renal tension will often prevent the tension on the heart, and the circulatory apparatus generally, in their efforts at equalizing the circulation of the blood. Hypertrophy of the heart wall and increased vascular tension follow the increased efforts of the heart.

Indications for relieving the tension surgically in cases of nephritis, however arising, are: (1) Progressive signs of kidney deterioration, as shown by the persistence or increase of albumen when it should be diminishing or disappearing from the urine, as in the natural course of inflammatory disorders ending in resolution; (2) suppression of urine, or approach to this stage; (3) where a marked disturbance of the heart and circulatory apparatus arises in the course of inflammatory renal disorders.

There is but a slight risk in the operation and it should be undertaken where there is a fair prospect of saving a life, or avoiding the invalid life which is inseparable from a chronic albuminuria arising out of a nephritis. There is seldom much bleeding or even necessity of tying a vessel.

As to which organ should be selected for operation, unless there is some indication, as pain in one of the kidneys, it matters little which of the two is selected. In double nephritis the relief of tension in one kidney aids the other.

A. L. W.

Double Ureter of the Right Kidney.—By CHARLES M. SCUDDER, M.D. (*The American Journal of the Medical Sciences*, July, 1901, page 46).

Scudder reports a case, the ninth recorded instance, of the blind ending of a supernumerary ureter. This case was associated with acute abdominal symptoms of a marked character.

The patient was a child twenty months old. It suddenly became ill, with fever, and symptoms that resembled intestinal obstruction. Exploratory laparotomy revealed a normal intestinal tract, but there was found a retroperitoneal tumor, extending from the kidney on the right, down in curves, across the lumbar region and behind the bladder. The left kidney was normal. Owing to the child's condition, the abdominal incision was closed, and the child died the next morning.

Upon autopsy, the sausage-like mass was found to represent an enormously dilated ureter of the right kidney, filled with a thin, yellowish fluid containing leucocytes and bacteria, and ending blindly as a closed sac about the diameter of the thumb, in the neighborhood of the orifice of the urethra, the internal meatus. It ran transversely across the axis of the body four or five times, the loops being bound together with connective tissue. It was probably 45 cm. long and 11 cm. in diameter at its widest part. The entire kidney was large, measuring 9 cm. in length.

The literature is mentioned.

A. L. W.

Gonorrheal Myositis.—By MARTIN W. WARE, M.D. (*The American Journal of the Medical Sciences*, July, 1901, page 40).

Ware reports a case of gonorrheal myositis in a man aged 35 years. Four weeks after the contraction of gonorrheal urethritis he was attacked with pain in the left knee-joint, attended with a chill and fever. Three weeks later he complained of pain in a shoulder. The region showed fulness, no redness, and active abduction was impossible. By palpation an exquisitely tender area of

induration was elicited in the group of muscles which constitute the posterior axillary fold. It was about the size of a walnut. The daily elevation of temperature was about 100° F. Under expectant treatment (iodin locally) the mass not only grew, but became more painful. It was incised under local anesthesia. The muscles were sodden, grayish in color, and friable in the deeper layers. There was no pus, though there was a free exudation of serum. A piece of the muscle was excised. Though relief from pain followed the incision, it took six weeks for the wound to close.

Gonococci were found in the urethral discharges. They were also found in the smears made from the serum found in the muscles, but they were exceedingly sparse. The cultures failed, though they showed the presence of no other organism.

The author explains the location of the gonococci in these muscles either as a metastasis or as an extension of the inflammation from adjoining joints or bones. The latter, he thinks, is more likely. The literature of the subject is thoroughly discussed, there having been but three cases previously recorded, based upon clinical observation solely.

Treatment is largely expectant. For the pain, dry heat, hot salt, sand-bags, as in joint disease, aided by local anodynes, guaiacol, gaultheria and menthol. Massage is recommended after the acuteness of the process has passed away. Incision is thought to accomplish depletion and relieve the tension, in very painful cases.

A. L. W.



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